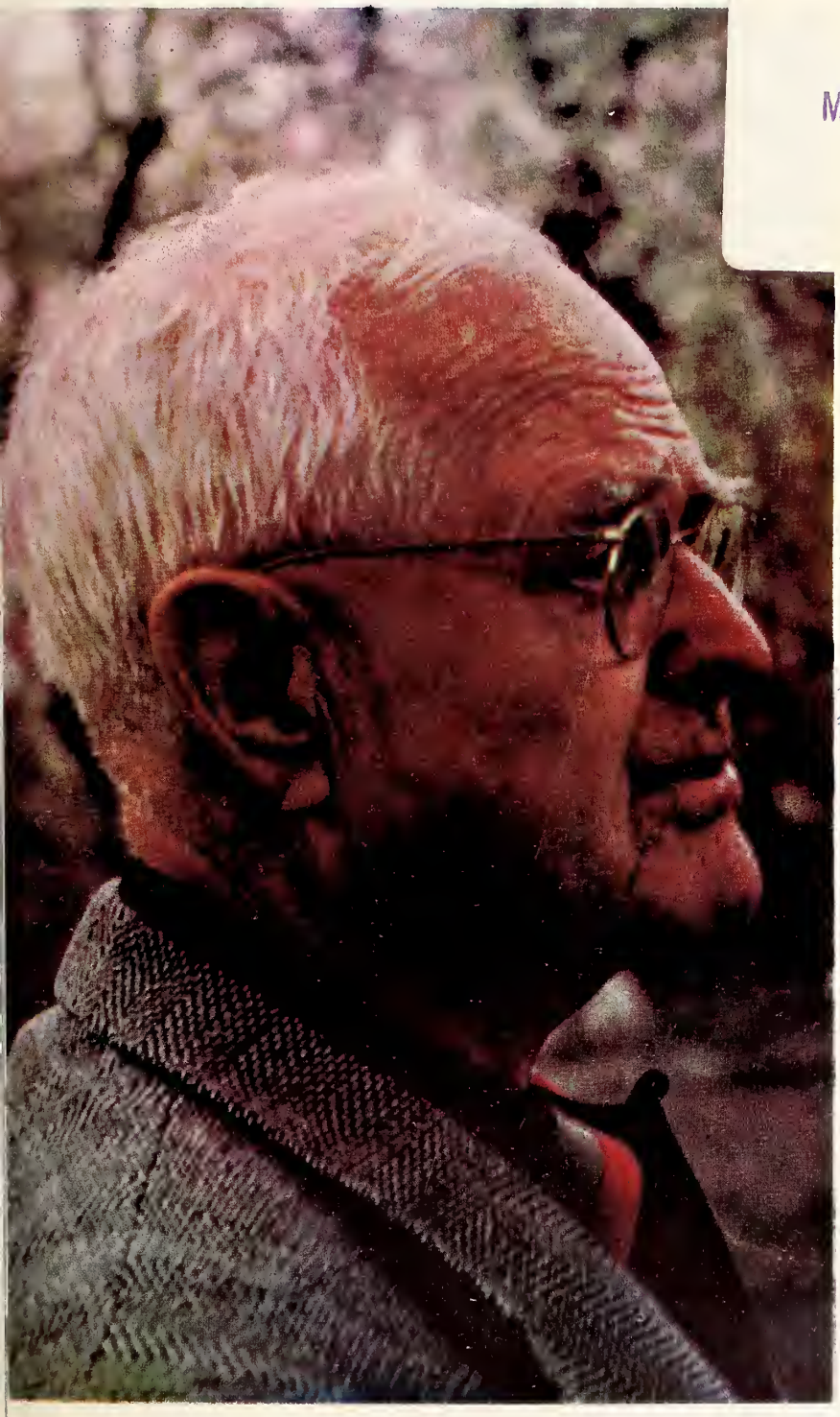

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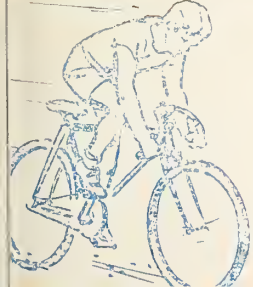


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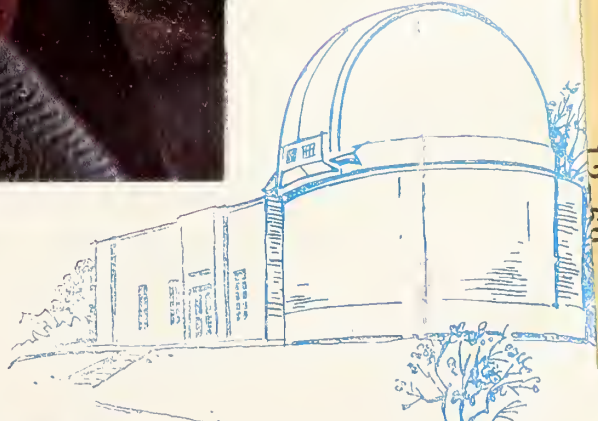




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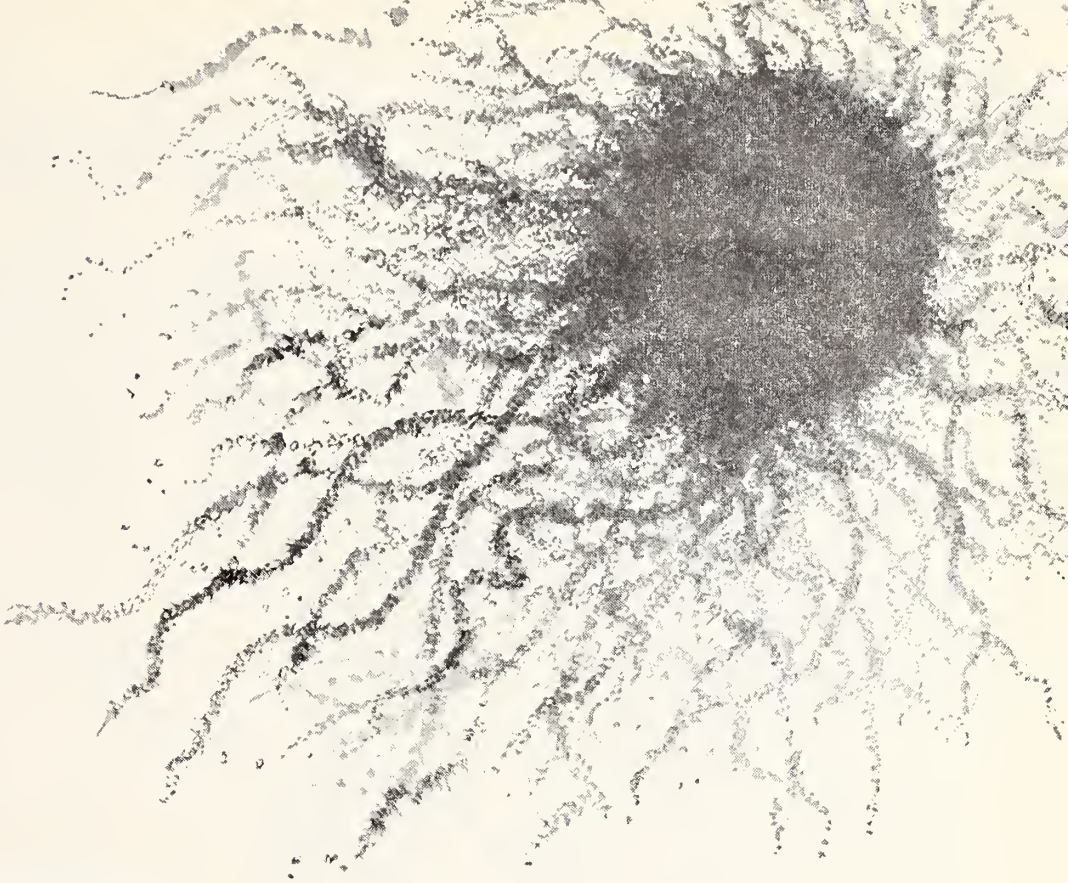
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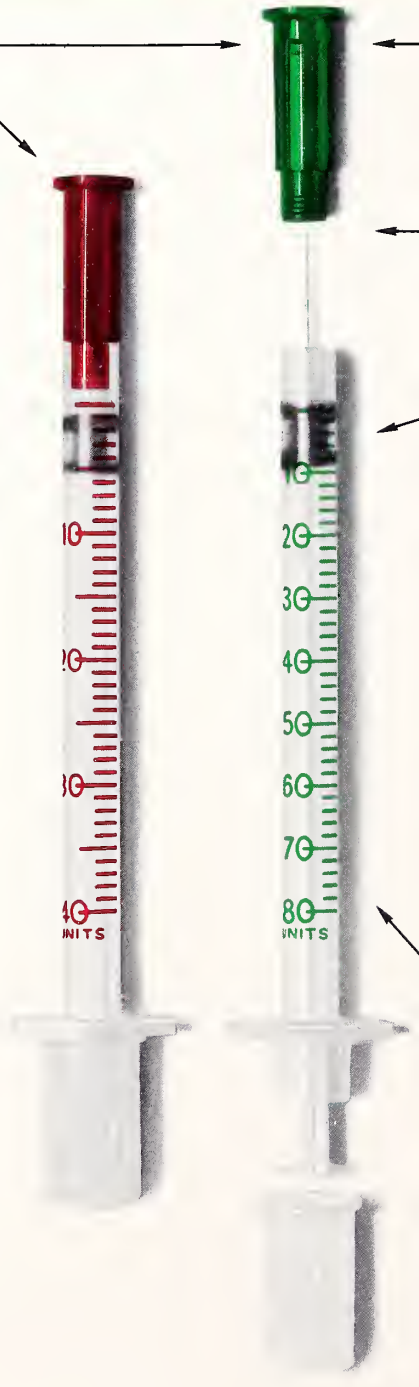
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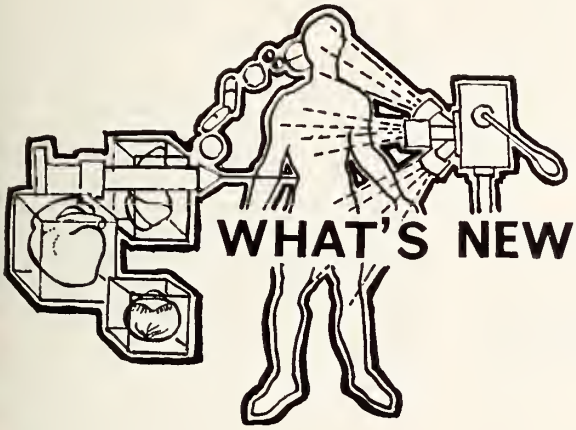
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WHAT'S NEW?

"Screening and Diagnosis in Diabetes Mellitus for the Physician" is a booklet written by Dr. Arthur Krosnick. It is published and distributed by The Upjohn Company through Diabetes Detection Program, 342 Madison Ave., New York City 10017. It presents in digest form the diagnostic criteria and rules for screening for and diagnosing diabetes. It and another booklet by Dr. Krosnick, "Classification and Management in Diabetes Mellitus for the Physician," are available to physicians and medical societies by writing the Diabetes Detection Program at the above address.

* * *

Schering has introduced a new antibiotic, Garamycin Injectable (gentamicin sulfate injection). It is effective against a wide variety of pathogenic gram-negative bacteria and has shown impressive activity against both the pseudomonas and proteus species. The drug is administered intramuscularly and attains a high serum concentration within one hour. Effective concentrations persist for six to eight hours.

* * *

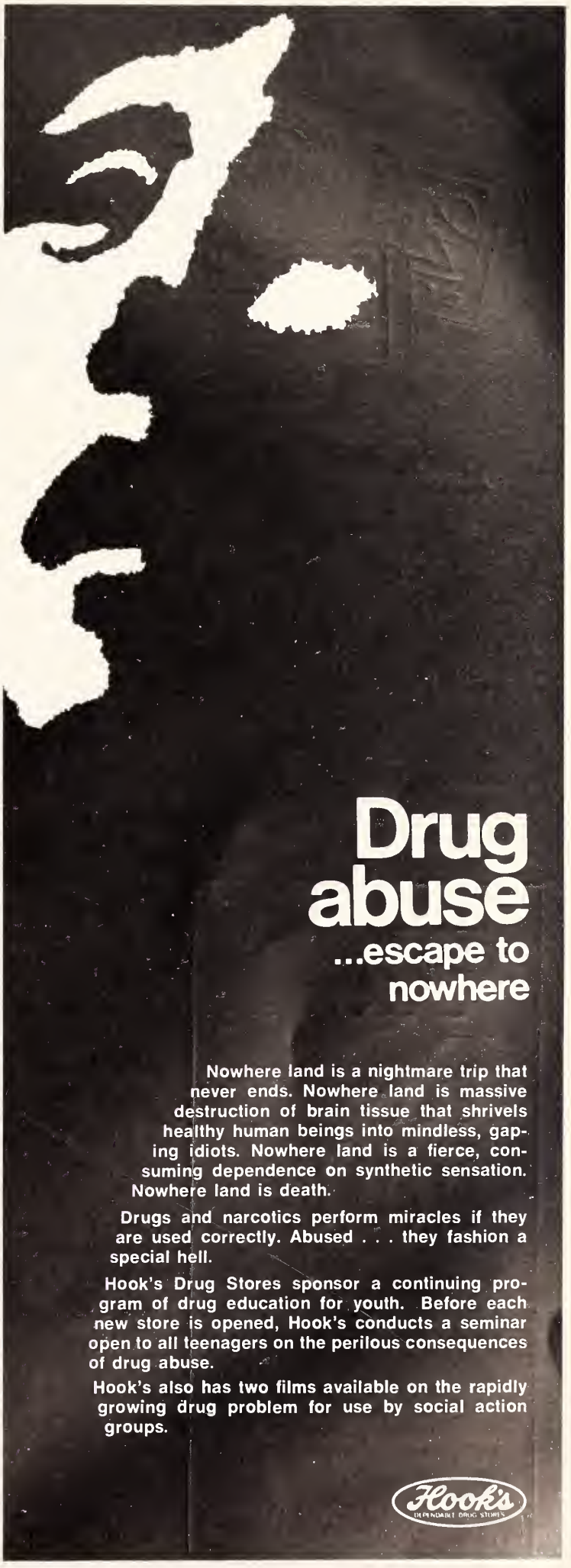
Fairfield Surgical & Medical-Electronics has a new Crash Cart which contains all necessary electronic and mechanical apparatus for resuscitation in an attractive and highly mobile unit. It includes the Fairfield modular DC-Defibrillator, Cardiac Synchronizer, Cardiac Pacemaker, and Cardioscope. The latter two may be operated either on AC or self-contained batteries, and can be lifted out to travel with the patient. Respiration equipment with oxygen bottles is included.

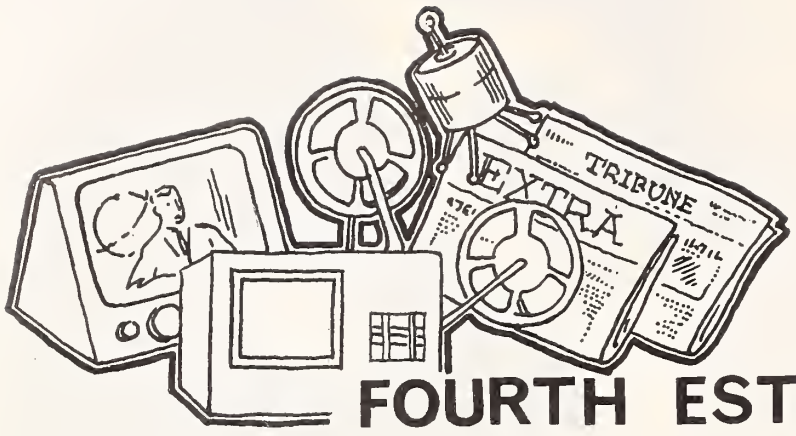
* * *

J. T. Posey is now marketing a new type of ambulatory mitt. The mitt provides a certain amount of freedom for the wearer yet prevents the patient from using his hands for destructive purposes. It may be laundered.

* * *

News of what is new in the medical supply industry is compased af abstracts from news releases by manufacturers—of phormaceuticals, clinical laborotary supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does nat necessarily constitute an indarsement of o praduct or recommendation for its use by THE JOURNAL or by the Indiana State Medical Assaciation.





FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Progress in Abortion Legislation

In March of 1967, the Indiana General Assembly passed a bill liberalizing somewhat Indiana's restrictive abortion statute. Had this measure become law, Indiana would have been the first state in the nation to take this much-needed action. We would have, in effect, been providing national leadership in an important, though controversial, area of social legislation.

Unfortunately, Governor Branigin vetoed the bill. And a month later it fell to Colorado's Governor, John Love, demonstrating his compassion and his courage, to sign into law the first liberal therapeutic abortion statute in the country. Since that time, ten other states have followed suit.

Hawaii is the latest state to act. And its law—put on the books last week—has broken *new* legal and political ground. Hawaii legalized abortion on request, leaving the decision about the operation to the woman herself and to her physician. All the other laws specify some medical need be established and require that the operation be approved by a committee of disinterested physicians.

The only limitation in the Hawaiian law is a three-month residency requirement. But a similar bill *without* a residency requirement is under consideration in Arizona. And other abortion reform bills are at various stages in the legislative process in several other states.

All of this progress in a period of less than three years demonstrates, we believe, the great need for this type of legislation and the growing public enlightenment about the problems created by restrictive abortion laws.

While Indiana no longer has the chance to lead, we hope the action of these other states will prompt the 1971 Indiana General Assembly to try again to give Indiana a law attuned to modern attitudes on abortion and the rights of women.—WFBM Radio Editorial.

Parents Outnumbered

Lots of parents these days are talking about their lack of communication with their youngsters. They talk about the "generation gap" or maybe that things are "out of balance." The sad thing about it is that the parents are outnumbered, and that's one thing they can't blame on the children.—*The Frederic (Wis.) Inter County Leader.*

Liberalizing Abortion Laws

One of the most significant things about the suit filed by the Indiana Civil Liberties Union to have the Indiana criminal abortion laws declared unconstitutional was omitted by most newspapers if they, indeed, ran the story at all.

Changes in abortion laws are advocated by many prominent people including:

Dr. Robert D. Arnold, a physician in obstetrics and gynecology, member of the American College of Obstetricians and Gynecologists and numerous other professional and community organizations.

Dr. Neil R. Strickland, a physician in obstetrics and gynecology, a fellow of the American College of Obstetrics and Gynecology, author of several articles in his field and a member of numerous other professional and community organizations.

Dr. H. C. Moss, physician and surgeon, member of the American College of Surgeons and numerous other professional and community organizations.

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Dr. Paul L. Guise, a physician in medicine and member of numerous professional and community organizations.

Dr. Walter L. Owens, a physician in obstetrics and gynecology, fellow of the American College of Obstetricians and Gynecologists and numerous other professional and community organizations.

Laws similar to Indiana's 1905 Indiana law on abortion were held unconstitutional by California's Supreme Court and by the U.S. District Court for the District of Columbia.

The ICLU lobbied for a bill which was passed by the Indiana General Assembly in 1967 but was vetoed by Gov. Roger Branigin. That measure would have created only a modest expansion of the circumstances under which legal abortions could be obtained.

It is argued that the state's interest in abortion laws has changed. While it may have once been desirable to expand the population on a frontier society, legitimate state interest today requires the fostering of a rational growth rate and the prevention of over-population.

Balanced against the interest of the state is the overriding concern of the women of our society.

As was stated in the District of Columbia case: If woman is viewed as an individual entity, and not as a vessel for propagation, without doubt each time she determines to bear or not to bear a child she is making perhaps the most fundamental choice of her life.

It is for these reasons that at least 10 of our states have liberalized their laws on abortion.—*Frankfort Morning Times*, Apr. 21, 1970. ◄

Letters to the editor

To the Editor:

This might be headlined, "Snipers and Riots Furnish Martyrs Needed to Produce Public Reaction Desired" (desired by communists).

Time Table:

1. April 10, 1970, "Yippie" Jerry Rubin, convicted member of the "Chicago 7," told over 1,500 students at *Kent State University, Ohio,* to burn their books, *kill their parents,* and burn down the suburbs. "*Quit being students,*" he urged, and "*become criminals.*" "*We have to disrupt every institution and break every law.*" While he spoke, money enough to fill two of his flight bags was collected for Rubin in paper buckets. (Note: You can buy Rubin's book here at newsstands and read plans to destroy our country.)

2. Monday, May 4, 1970, the greatly outnumbered contingent of about 100 National Guardsmen were villified, cursed and attacked by a considerably larger mob of "students" accompanied by many curious and misguided students.

Early reports mentioned sniper fire preceding the defensive fire of the guardsmen. Let's not jump to conclusions. The public was supposed to have been stampeded into believing that a "Right Wing Extremist" assassinated President Kennedy. The public is now supposed to react powerfully against the National Guard, against law enforcement officers and against the Governor of Ohio.

Could it be that a sniper or two, purposely taking *head* shots at a few relatively innocent, more decent looking students, under the cover of the provoked defensive *low* fire of the Guard, did the killing? You may never know unless we get the whole story.

I hope the police and F.B.I. ballistics experts give us the answers and the news media report the *whole true story* and not give us just "*All the News that Fits.*" (Fits the purpose which is to deceive the public into believing the forces of law and order were the culprits). We shall see. In the meantime try to learn all the truth before jumping to conclusions.

You didn't teach your kids the May 6th slogan chanted by the mob at I.U.—"ONE, TWO, THREE, FOUR, LET'S STOP THE F—N' WAR." You saw it on T.V. that night or did you miss it? WHO TAUGHT THEM?

Sincerely yours,
HUGH S. RAMSEY, M.D.
Bloomington

To the Editor:

How to Pre-determine the Sex

There are two kinds of sperm cells. One half of the sperm contain a Y chromosome, the other half an X chromosome. Union of the Y sperm with an egg cell or ovum results in a male, XY zygote, and union of an X-containing sperm with an ovum gives an XX or female zygote.

Cattlemen for years have been able to predetermine the sex of calves. They have found that the Y sperms are more active and therefore have a short span of life (one or two hours). The X sperms are slower and live longer.

Human ovulation occurs, as a rule, 14 days after the onset of the last menstruation. Therefore, if a female child is desired, coitus should occur on the 12th or 13th day, so that by the time ovulation occurs, the Y chromosome will have been spent or be lifeless and the slower, longer living X sperm will fertilize the egg.

If a male child is desired, coitus

LETTERS

Continued

should occur on the 14th or 15th day, at or soon after the time of ovulation. The exact time of ovulation is often indicated by a sharp abdominal pain on one side and also by a slight rise in the body temperature to 99°—99.2°.

JOHN R. FRANK, M.D.
Valparaiso

Letter to the President

My dear Dr. Steen:

This is to thank you for your letter of April 7th, anent fees to be paid to physicians under the provisions of the Medicaid Act.

I am 84, retired four years now, and so perhaps I write from a disinterested viewpoint. However, I always tried to alleviate the problems and sufferings of the poor so that my stance on this matter is identical with what it would be if I had many unpaid bills due me for services rendered to Medicaid patients.

Briefly, it is this—as physicians, who obtained the education we possess largely as result of labors of others, we owe a forever unpaid debt to society. We should, in my opinion, never quarrel nor complain over whatever fees we get from government for these services, but regard that as an honorarium, given to us over and above our reward for a good deed well done.

If the above attitude is maintained, the physicians of the USA will profit from public esteem far more than any pennies they obtain by bickering over a fee for services to the poor. This service they nearly all would have given graciously if there were no Medicaid and no financial remuneration.

In our prayers, at the end of a day's work, it might be a tiny thing in our favor when we seek forgiveness for our derelictions.

DAN TUCKER MILLER, M.D.
Fowler, Indiana ◄

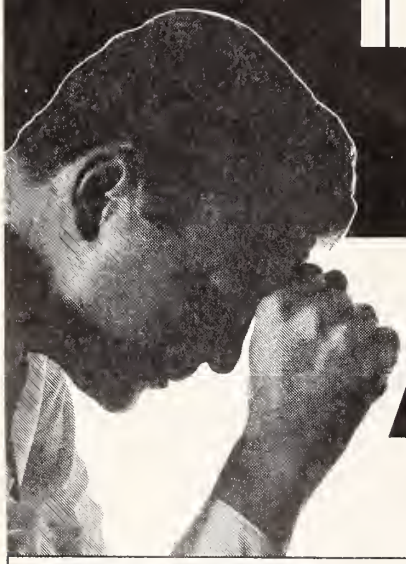
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T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



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Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
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EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

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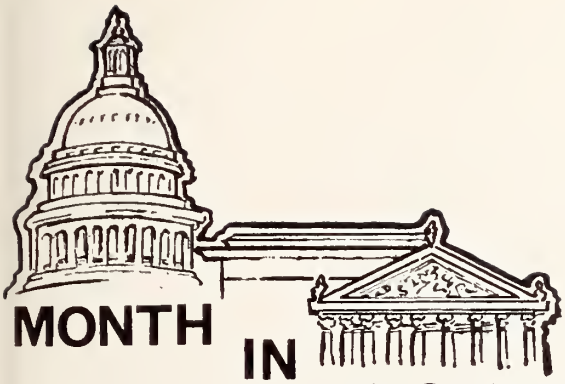
Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
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Contraindications—Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

THE American Medical Association urged that Congress appropriate as much money as possible for medical education to help "meet the pressing need which exists today for an increased number of physicians."

TESTIFYING before a House appropriations subcommittee, Dr. C. H. William Ruhe, director of the AMA's Division of Medical Education, said the association recognized the need for an overall reduction in federal spending to combat inflation.

"IN VIEW OF THIS," he said, "we believe that in any appropriation priorities established for all government programs, those which affect health care should be given primary consideration. Further, because of the special need that exists at this period in our history for more physicians, we urged that appropriations relevant to the production of physicians be given first priority."

DR. RUHE pointed out that funds had not been appropriated for a backlog of approved applications for construction of facilities for new medical schools and expansion of existing schools as authorized by the Health Professions Education Assistance Act, the Health Research Facilities Construction Act and the Medical Library Act. He also said that full funding in the amounts authorized by the Health Manpower Act of 1968 is necessary to permit construction of new and expanded facilities before major enrollment increases in medical schools will be feasible.

"THE PROVISION in the Administration budget of funds for the Physician Augmentation Program and for special improvement grants has been a considerable incentive to medical schools to expand enrollments," Dr. Ruhe said. "But many schools have already increased their enrollments to full capacity in their existing facilities. Others have been in serious financial distress and are in desperate need of increased operational support to maintain their present enrollments or even to survive. It must be recognized that such schools will need further facilities and operating funds which are necessarily tied to increased enrollments."

THE subcommittee's hearings were on appropriations for the 1971 fiscal year beginning this July 1.

USING FUNDS appropriated for the current fiscal year, 1970, the Department of Health, Education and Welfare recently announced

Continued

nearly 300 grants to schools of medicine and other health professions totalling more than $54 million.

ABOUT $7.6 million went to 27 schools of medicine and osteopathy under the Physician Augmentation Program. A government spokesman said the grants would enable the schools to increase their first year enrollment by 395 students.

ABOUT $46.5 million in institutional grants was allotted to 260 schools in the health professions—medicine, dentistry, osteopathy, podiatry, optometry, pharmacy and veterinary medicine. These funds also will enable the schools to add more students through purchase of new teaching equipment, improvement of the physical teaching environment, purchase of supplies, books and periodicals, and other expenditures to improve the education of students.

AMA SUPPORTS EXTENSIONS OF RMP

THE American Medical Association supports extensions of the Regional Medical Programs and, with some reservations, the program for Comprehensive Health Planning and Public Health Services.

TESTIFYING BEFORE a House Public Health and Welfare Subcommittee, Dr. Bland W. Cannon, Memphis, Tenn., a member of the AMA's Council on Medical Education, emphasized that the AMA believes that RMP "should continue as a program of continuing medical education, with patient care being limited to demonstrations as an adjunct of the education and research processes."

HE SAID the AMA opposes legislation that would combine the individual programs.

"THESE PROGRAMS are relatively new and we believe should be evaluated, as well as allowed to develop further evidence of their individual strengths and weaknesses," he said.

DR. CANNON pointed out that the AMA House of Delegates last December affirmed its support of the concept of Regional Medical Programs and urged AMA members to participate at all levels in giving guidance to implementing the programs.

THE AMA SUPPORTS broadening the scope of the programs to include "other major diseases," in addition to heart disease, cancer and stroke, he said.

HE SAID a combination of the programs would result in a change toward emphasis on patient care in RMP.

"WE WOULD VIEW with grave concern any attempt to change this essentially educational program to a program for the provision of health services," Dr. Cannon said. "The medical profession today generally views RMP as a means of aiding the physician to provide better care to his patients. It is this attitude which has brought about the outstanding cooperation between practicing physicians and RMP and which has been a major cause of success for the program thus far. If RMP returns to an earlier concept of providing services to the patient,

rather than its present goal of assisting the individual physician to treat the patient more effectively, this cooperation will, in many cases, be lost. The program's beneficial accomplishments will then be diminished."

ALCOHOLISM LEGISLATION SUPPORTED BY AMA

THE American Medical Association supports in general, legislation (S. 3835) that would provide a comprehensive federal program for the prevention and treatment of alcohol abuse and alcoholism.

DR. MARVIN A. BLOCK, Buffalo, N.Y., a member of the AMA's Committee on Alcoholism and Drug Dependence, termed the measure "a major landmark in public policy" in the field.

"IT SETS FORTH the proposition that alcoholism is an illness which can and should be treated, and it commits national resources to the establishment and coordination of facilities necessary for treatment and rehabilitation," he said at a hearing of the Senate Subcommittee on Alcoholism and Narcotics. "We are in general agreement with this legislation."

THE BILL would establish a National Institute for the Prevention and Control of Alcohol Abuse and Alcoholism. The Health, Education and Welfare Secretary, acting through the institute, would be required to submit within one year a detailed federal program, develop model programs for states, and conduct research and educational programs. Federal grants would be authorized for prevention, treatment and rehabilitation facilities and programs at the state and local level.

DR. BLOCK specifically favored several of the bill's provisions, including one that treatment and control programs should be community based, whenever possible.

"INSOFAR as it is feasible and economically sound, most alcoholics should be treated in their own communities and not be relegated to a distant centralized institution for treatment," he said.

BUT THE AMA spokesman questioned some other provisions. He saw no need for a new institute. He said the present National Center for Prevention and Control of Alcoholism could perform the proposed institute's duties and responsibilities.

HE SAID the AMA also questions whether alcoholics should be made eligible for welfare cash benefits and for health care under other government programs, such as medicare and medicaid, on the ground that they are alcoholics.

NOTING THAT the legislation is concerned mainly with operation of programs by public and voluntary agencies, Dr. Block said: "WE SHOULD NOT OVERLOOK, however, the role that the private physician has played, and can play, in this important area. More and more, the physicians of this country are facing up to the problem of alcoholism in their daily practice. They are recognizing that, as difficult as alcoholism may be, it is an illness which can be dealt with, and that they can help their patients in cooperation with other professionals in the community."

THE BILL was introduced by Sen. Harold E. Hughes (D., Iowa), a

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recovered alcoholic and chairman of the subcommittee, and 37 co-sponsoring senators.

L-DOPA APPROVED FOR PRESCRIPTION USE

L-DOPA, a new treatment for Parkinson's disease, has been approved for general prescription use but it may be several months before it is available in ample supply.

"CLINICAL TESTS conducted during the past several years by medical researchers and two major drug firms have demonstrated the usefulness of L-dopa in the treatment of this disease which now afflicts possibly a million persons," FDA Commissioner Charles C. Edwards, M.D., said.

APPROVALS were granted to applications made by Hoffman-LaRoche, Inc., and Eaton Laboratories Division of the Norwich Pharmacal Co., Norwich, New York. Both firms conducted studies in animals and humans to establish the drug's safety and effectiveness. An analysis of these studies indicated that benefits to the patient outweigh the risks involved, the FDA said.

"HOWEVER, the Food and Drug Administration will require both drug firms to continue research into the drug's long-term effects and make certain it is safe and effective for long-term use, Dr. Edwards said. "This is the first time that FDA has included such a requirement in a new drug approval."

IN ORDER to give a balanced picture, Edwards pointed out that:

—Clinical studies have shown that approximately one-third of the patients receiving L-dopa do not respond favorably.

—Side effects have been reported in a majority of patients, some of them quite unpleasant and others even dangerous. Whether or not the use of this drug is justified in the very early stages of Parkinson's has not been established.

—Since Parkinsonism is a chronic disease, patients will have to take L-dopa for long periods of time. We don't know how these patients will react after 5, 10, or 15 years of treatment. Because of our limited knowledge of the drug's long-term toxicity, it is conceivable that it could reverse the benefit to risk ratio.

THE NAME L-dopa comes from the initials of an amino acid, levodihydroxyphenylalanine. Dr. George C. Cotzias, of the Medical Research Center, Brookhaven National Laboratory in Upton, New York, was the first to demonstrate the usefulness of L-dopa at high dosage levels. Dr. Andre Barbeau, director of the Department of Neurobiology at the Montreal Clinical Research Institute, has been studying the new drug for the past 10 years and is also credited with aiding in its development as a treatment for Parkinsonism.

MARKED INCREASE IN SYPHILIS

A MARKED INCREASE in syphilis cases in the United States was reported by the National Communicable Disease Center for the first four months of this year.

Continued on page 752.

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THE infectious disease jumped as much as 50% or more in some areas while the nation as a whole experienced an increase to 6,861 cases from 6,203 for the same four-month period last year. One of the biggest increases was noted in New York City where 1,241 cases were reported as compared with 863 for the same period last year.

CONGRESS EXTENDS HILL-BURTON PROGRAM

CONGRESS approved legislation extending the 24-year-old Hill-Burton federal-aid-to-hospitals program for three years with authorized expenditures of $2.76 billion.

THE FINAL FORM of the legislation was a compromise agreed to by House and Senate conferees after the two branches of Congress passed differing versions.

THE AUTHORIZED expenditures broken down: $1.26 billion for various state grant-in-aid programs for construction and modernization of hospitals, and $1.5 billion for loan guarantees. The measure also authorizes funds to subsidize interest payments on loans up to three percent.

THE LEGISLATION approved by the conferees followed the House version for the most part. The Senate had approved a five-year $6.2 billion bill. The conferees eliminated entirely a Senate provision for $750 million of direct loans for public hospitals, which was strongly opposed by the Nixon Administration.

ALSO KNOCKED OUT was a Senate amendment for a new formula for allocation of federal funds in a way that would have benefited large industrial states. However, the Health, Education and Welfare Department was directed to make a study of possible formula changes and report to Congress in two years.

APPOINTED DEPUTY ASSISTANT SECRETARIES

TWO PHYSICIANS and a management expert were appointed Deputy Assistant Secretaries for Health, three long-vacant posts in the Department of Health, Education and Welfare.

THE appointees are:

—Dr. Thomas C. Points, Oklahoma City, Okla., for Health Services. He is an alternate in the AMA House of Delegates and on the AMA Council on Health Manpower. As director of the Department of Preventive Medicine at the University of Oklahoma Medical Center, he helped establish the state's rural health project, "Project Responsibility."

—Dr. LeRoy A. Pesch, Buffalo, N.Y., for Health Manpower. He was dean of the School of Medicine at the State University of New York at Buffalo.

—Gerald Riso, New York City, formerly with Booz, Allen and Hamilton, Inc., management consultants, for Policy Implementation.

STILL VACANT in early June were the posts of Deputy Assistant Secretary for Research and Development and for Environmental Health and Prevention of Disease Problems.

DR. MORRIS E. CHAFETZ, director of Clinical Psychiatric Services of Massachusetts General Hospital, Boston, was selected to succeed Dr. Jack Mendelson as chief of the National Center for the Prevention and Control of Alcoholism. Dr. Mendelson is returning to a teaching post at Harvard Medical School.

TWO high-ranking officials left the HEW Department with critical blasts directed at their bosses.

DR. STANLEY F. YOLLES said he quit as director of the National Institutes of Mental Health because the Nixon Administration had abandoned the mentally ill. HEW Secretary Robert H. Finch said he was fired because he was not cooperative. Dr. Yolles was succeeded by Dr. Bertram Brown who had been deputy director. Despite the dispute, Dr. Yolles will stay in HEW until Nov. 1 as an assistant for mental health to Dr. Vernon Wilson, new director of HEW's Health Services and Mental Health Division. Dr. Wilson succeeded Dr. Joseph T. English who resigned quietly to take a high public health post in New York City.

ROBERT J. MYERS, chief actuary of the Social Security Administration for 23 years, resigned with a charge that Social Security Administrator Robert M. Ball had attempted "to muzzle and intimidate me with regard to three speeches that I was making in support of the Nixon Administration's position on social security legislation." Ball denied it, and countered that Meyers, who was supposed to be an objective career civil servant, had wanted to be a policy spokesman.

MYERS HAD publicly accused Ball and other high SSA officials of being "expansionists" in the social security field with a goal of the federal government providing a retirement income level virtually as high as before retirement.

IN A LETTER of resignation, Myers told Finch that these officials "have not—and will not—faithfully and vigorously serve the Nixon Administration." ◄

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Supervised by THE COUNCIL
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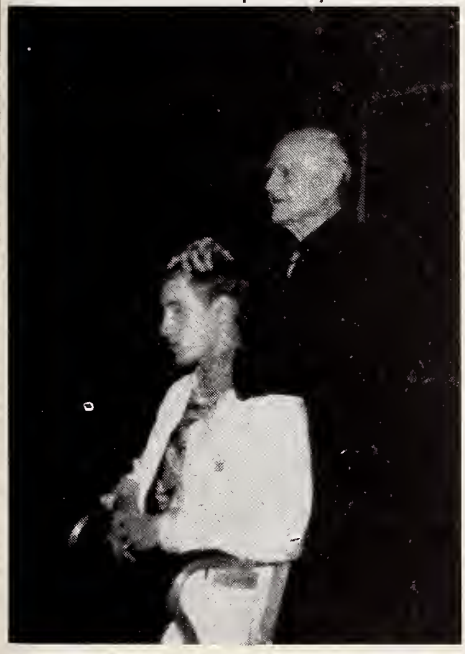
"Age cannot wither him, nor custom stale His infinite variety"—(paraphrased from Shakespeare).

GOETHE LINK, M.D.--Student and Teacher

AUSTIN L. GARDNER, M.D.
*Indianapolis**

From whom did he learn and to whom did he impart his knowledge, this giant of a little man?

First and most important of all he learned from nature and this learning stemmed from interest—an intense inquisitiveness—evidently consuming at times—nurtured by a man who showed him that he was living in the world and not appreciating its beauty and order. This man was an Indianapolis dermatologist named Alembert Winthrop Brayton for whom a library at General Hospital is named. The realization of what he was missing in the world around him came about as Dr. Brayton, while walking with Dr. Link, leaned over and picked up a plant and launched into a fascinating discussion of the secrets of nature, unlocked by knowledge and enlightened observation. It was a lifetime inspiration.



DR. LINK demonstrating method of palpation of the thyroid on subject Richard Shepherd, a senior at the I.U. School of Medicine.

George Crile, Charles Mayo, Frank Lahey, Joseph Price, Reginald Fitz, Morris Richardson, the students of Halsted, and other great surgeons of the first half century were visited by Dr. Link. He made friends, he observed and he learned.

Joseph Price, the great surgeon of Philadelphia at the turn of the century, was considered by Dr. Link to be the finest technician. He believed in great simplicity of plan, execution and instrumentation. Dr. Link's father had studied under Dr. Price and with this introduction, Dr. Link proceeded to spend as much time as possible in his clinic. Dr. Price sent him to his friend Morris Richardson in Boston who took Dr. Link with him to operations in the hospitals around Boston. A vivid memory of Dr. Richardson was a lesson in operative surgery. Dr. Richardson, one day, heard of a young woman dying of appendicitis whom he had previously operated for an ovarian cyst. He was quite pensive and Dr. Link inquired about it and learned of the event. Dr. Richardson punctuated the experience with the dictum of, "Never leave the appendix in the abdomen when operating for an unrelated condition."

Dr. Link's experience spans the century. He saw Reginald Fitz who, in 1886, described the clinical entity of appendicitis. Fitz described to Dr. Link his struggle for acceptance of his views against a New York pathologist who insisted on perithyphlitis as the cause of the symptom complex. Fitz reviewed Dr. Link's paper on chronic pancreatitis and remarked that he was glad to see that there were young men in the West working on difficult medical problems.

His respect for appendicitis resulted in the removal of two of his children's appendices prophylactically

* An Indianapolis surgeon, Dr. Gardner has been a close friend of Dr. Link for many years and assisted him in his last operations.

Special acknowledgment is made for Dr. Gardner's editorial assistance in planning and processing this issue.

and in an abrupt trip home from Mexico when his third child developed appendicitis in Indianapolis. Yet when he himself suspected appendicitis, he delayed proper management for economic reasons. This resulted in a scolding by Dr. George Crile who removed his retro-cecal appendix. Dr. Link said he had to choose "between the sheriff and the devil."

He sought out the students of Halsted to learn his technic of operative surgery. The gentle handling of tissues became his hallmark and he came to pride himself in the silk technic of ligation. From Mont Reid of Cincinnati he learned a great deal about wound healing and was given a screen to separate the field from the anesthetist. His technic of thyroidectomy is essentially Halsted's technic. He did not believe in Lahey's teaching of recurrent laryngeal nerve dissection and tended to follow Crile's dictum to stay well away from the nerves as the best means of preserving them.

Dr. Link became active in thyroid surgery well before it was appreciated by Plummer that iodine was efficacious in the preparation of thyrotoxic patients. He visited the Mayo Clinic and Charles Mayo told him of the high mortality of thyroid surgery stating that four of his first 16 patients had died. A study of the anatomy of the head and neck resulted in his ability to tie the thyroid arteries which was the best preparation for thyroidectomy available and led directly to his work primarily in thyroid surgery.

There were other great teachers—John B. Murphy, Robert Coffey, Thomas Noble, Sr. and Joseph Rilus Eastman of Indianapolis. Dr. Eastman heard that Dr. Link was undertaking experimental work in the treatment of mitral stenosis and advised, "Goethe, get on to something that you can make a living at." He also learned from his father, a surgeon in Petersburg, Indiana. He accompanied him on rounds as a boy assisting in operations. The elder Dr. Link died shortly after his son joined him in practice.

The non-medical teachers were legion for he learned from anyone who would talk. He stood beside Wilbur Wright at the 500 Mile Track as he used a measuring device to determine the world record altitude of 1500 feet while a friend flew a new plane. He learned from zoo keepers, balloon racers, farmers and immigrants, from jewelers, politicians, artists, prostitutes and grave robbers.

And this man, who had the drive of John Hunter and of the elder Mayo, taught carefully and patiently all who wished to learn. He loved to teach about birds, snakes and stars, as well as medicine. His lecture on thyroid examination for doctors and students was never complete without palpating the neck of several students and no clinic on preoperative evaluation was complete without a bare-chested auscultation. Nurses were gently instructed, generously thanked and never taken for granted.

And of course he taught himself—he utilized the time riding on the interurban around Indiana to practice knots—and those gnarled fingers today can tie a square knot faster and more efficiently than many accomplished practicing surgeons. He taught himself ureteral catheterization utilizing light from a single candle.

It is not clear why Dr. Link did not go abroad to study. He evidently did not feel the need nor the inclination. He once took over a Dr. Wheeler's practice at Illinois and 16th Streets, grew a large mustache to appear older, while Dr. Wheeler went to Europe to study. When Dr. Wheeler returned he confided that he had learned very little. This might have had some effect on his decision not to go abroad.

His preoccupation with teaching is best exemplified by an experience last summer when a group of Boy Scouts and several fathers visited his home for an evening of scientific enlightenment. The fathers crowded to the front and asked searching questions, obviously enjoying themselves to the fullest. The following day when it was pointed out to Dr. Link that the men had especially enjoyed the evening, he indicated surprise, thinking that they were all boys, a tribute to his pedagogical stance and to the father's youthful curiosity.

He will stop learning only when there is no breath—but his teaching will never cease.

Mary Moreno didn't wear safety belts because they dirtied her dress.



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Dr. Goethe Link--Astronomer

FRANK K. EDMONDSON, Ph.D.
Bloomington*

HARLOW SHAPLEY once said that two of the most important contributors to the advancement of astronomy were Andrew Carnegie and John D. Rockefeller. Dr. Goethe Link could be added to this list, but he knows more about astronomy than the other two did.

I first met Dr. Link in the fall of 1937. I was a new I.U. faculty member that year, and Professor W. A. Cogshall, then head of the I.U. Astronomy Department, took me to Indianapolis to hear Harlow Shapley talk to the Contemporary Club. Dr. W. N. Wishard Jr. was president of the club, and he had arranged for Professor Shapley to see the Goethe Link Observatory which was then under construction. Professor Cogshall and I stopped to see the partly finished observatory on our way to the lecture and there we joined Professor Shapley and the group Dr. Wishard had brought down from Indianapolis. I remember Dr. Wishard saying: "Goethe, you are going to have to operate in all doubtful cases to pay for this."

Dr. Link had been a leader in establishing the Indiana Astronomical Society, an organization of Indianapolis amateur astronomers. and the observatory started out as an activity of that group with Dr. Link footing the bills. He hired an engineer to design the telescope mounting, got a plan for the building from Russell W. Porter who was an important figure in planning the 200-inch Palomar telescope, and employed some of the expert telescope makers from the amateur group to grind and polish the mirror surface. All of this was under way at the time of the Shapley visit, and we stopped to see the machine shop and optical shop in Indianapolis on our way to the lecture hall.

Dr. Link's original intention was to make the observatory available to all of the colleges and universities in the area. However, I.U. has the only astronomy department in the state and was the only institution to show a serious interest in the use of the observatory for both research and teaching. Herman B Wells during his first year in office provided funds for a post-doctoral fellowship for research at the Goethe Link Observatory, and Dr. James Cuffey came from Harvard in the fall of 1938 to fill this position. Dr. Cuffey assisted in the final optical tests on the mirror and put the telescope into regular operation in the summer of 1939.

World War II interrupted the work of the observatory and Dr. Cuffey served in the U.S. Navy teaching navigation at Annapolis. He returned to I.U. in 1946 as a regular member of the faculty and resumed his research programs at the observatory Courses leading to a Master's degree were established and the 36-inch telescope provided data for several theses.

"Lost" in Space

In the winter of 1947-48, the International Astronomical Union requested large scale participation in a program to gather data for improving the orbits of minor planets (asteroids) which became "lost" during the war. Dr. Cuffey and I agreed that the Goethe Link Observatory had an obligation to participate. However many of the "lost" asteroids were so far from the ephemeris position that the small angular field of the 36-inch telescope made it inefficient for searching through large areas of the sky. Fortunately, the Cincinnati Observatory had an excellent wide-angle 10-inch lens which was offered on indefinite loan. I.U. agreed to provide funds for the mounting and Dr. Link agreed to provide funds for the building to house it. Very soon after this agreement was reached Dr. Link decided to give the observatory to I.U., and the transfer was made in 1948.

Dr. Link's generous gift made an enormous change in the potential of the I.U. Astronomy Department. He gave us a large telescope, a vit

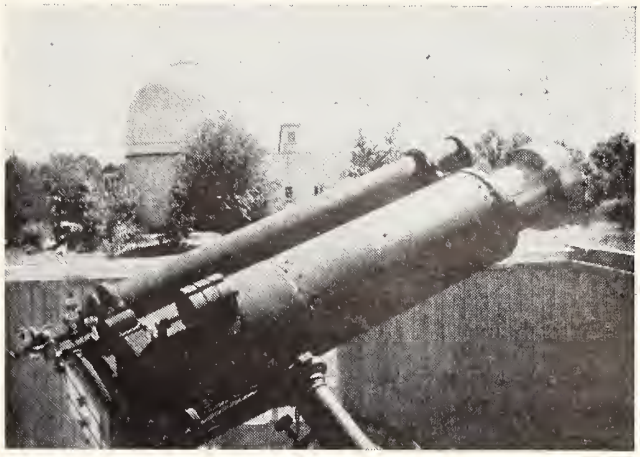


HARLOW SHAPLEY visits with Dr. Link in his home, January 26, 1969.

* Chairman, Department of Astronomy, Indiana University, Bloomington.



THE Goethe Link Observatory.



THE 10-inch telescope and the 36-inch telescope dome in the background.

ement which we had lacked and nich is necessary to support a grad- te program in astronomy leading to Ph.D. degree. The Ph.D. program as approved during the academic ar 1948-49 and budgetary provision increase the size of the astronomy culty was made in 1949-50. Our st Ph.D. was awarded at the June, 53, commencement, and our 40th ssed his oral final exam on May 1970. Forty astronomers have re- ived their professional training as a rect consequence of Dr. Link's gift the Goethe Link Observatory to J. Their teaching and their pub- hed research will be an enduring onument to Dr. Link.

From 1949 to 1966 the Goethe Link bservatory asteroid program found ost of the "lost" objects that were t too faint for the 10-inch telescope. nce 1966 the 10-inch has been used for other work, and we have been providing data from the plates in our files to orbit computers as requested. 6267 plates were taken with the 10-inch during the 17 years of active observing.

The Link Asteroid

Asteroids are given both numbers and names. The first asteroids to be discovered were named after minor female Greek and Roman deities. Later other names were allowed, and many famous astronomers and public figures have been honored in this way. In June, 1968, we had the opportunity to propose a name for asteroid number 1728 because it had been discovered at the Goethe Link Observatory. The citation prepared by Dr. Paul Herget, Director of the International Astronomical Union's Minor Planet Center at the Cincinnati Observatory, reads as follows:

"(*1728*) *Goethe Link.* Named in honor of Dr. Goethe Link, eminent surgeon of Indianapolis, Indiana, enthusiastic amateur astronomer, generous patron of astronomy at Indiana University, and donor of the Goethe Link Observatory."

Dr. Link was also elected a Patron by the American Astronomical Society in 1950. He is the only survivor of the four men who have been so honored.

Astronomy has been my direct contact with Dr. Link, but I have had an opportunity to observe the character of the man and see how wide a range of interests he has. The depth as well as the breadth of his knowledge is indeed impressive. As a man he exemplifies all of the virtues that can be described by the one word "civilized." ◄

Dr. Goethe Link--Living Medical History

WILLIAM M. LOEHR, M.D.
*Indianapolis**

THE John Shaw Billings History of Medicine Society was privileged to hear Dr. Goethe Link, the evening of September 10, 1969. He presented a most interesting and vivid account of his professional career. As president of the society, I introduced Dr. Link to the society in this way:

"Tonight we are privileged to hear a person who is living medical history in this city and state. It is always a unique opportunity to hear and see medical history from a living source rather than to learn this subject from books and periodicals.

"If I should recite the following news items to you, what year would you say these news items appeared?

"1. Dr. William Osler, age 49, is Professor of Medicine at Johns Hopkins University Medical School and teaching the future leaders of medicine in this country.

"2. New York City has just become the second city in population in the world, just behind the city of London.

"3. The United States took formal possession of Puerto Rico.

"4. Radium is discovered by Marie and Pierre Curie in their laboratory in Paris.

"5. William McKinley is President of the United States.

"6. The United States goes to war with Spain.

"Yes, the year was 1898. It was also the year our guest speaker graduated from Indiana University, receiving his A.B. degree. He received his M.D. from Central Medical College here in Indianapolis in 1902. He became an eminent and ingenious surgeon and particularly *the* thyroid surgeon of this entire area, having started as a general abdominal surgeon of great skill.

"In 1937, he presented Indiana University with a magnificent telescope and astronomical observatory (which was named in his honor), making Indiana University a major observatory among United States astronomical stations. His versatility in the most varied fields rivals that of his namesake, the great German—Goethe.

"Our speaker has graced the medical scene of this region for a long number of years, and I do not propose to tell you more of his career as I am sure he will do this in presenting his subject, which is titled—"Reminiscences." My friends, it is a great privilege and honor to present to you—Dr. Goethe Link."

* President, the John Shaw Billings History of Medicine Society, Inc.

Reminiscences*

GOETHE LINK, M.D.
Indianapolis

SINCE this is an historical society I shall tell you about early medicine and surgery in Indiana together with some erratic human nature incidents that my story may not be too dry.

My father, a college graduate with an A.M. degree, had taught school for several years and was the superintendent of a county seat high school when he decided to study medicine. He was graduated from Ohio Medical College in 1885. While there he took a course in surgery under Dr. Ransahoff who was a Fellow of the Royal College of Surgeons in England.

Though father practiced medicine he was especially interested in surgery, and he went to Philadelphia and studied under Joseph Price so that he could include surgery of the abdomen, just then becoming possible by the introduction of asepsis. He did the third Caesarean section in Indiana.

I was born in 1879 in Warrick County, Indiana when my father was teaching. My education was developed as rapidly as my age would permit and I graduated from high school in 1892. I practically grew up in my father's office and learned the name of every drug used as all doctors dispensed and carried drugs they needed. Today there are so many drugs that a large volume of drug names and facts relating to same of over 1400 pages entitled *Physician's Desk Reference* is issued each year and mailed to M.D.'s.

As my education continued in college it was planned with a view to my studying medicine and surgery. When at home I was taken by father to attend all operations as well as to his sick calls. After an operation it was my job to clean and care for his instruments. No hospital service was available and all operations were done in the home then.

After my Indiana University class 1898, I entered the Central College of Physicians and Surgeons at Indianapolis. Mine was the first four year course; previously it had been only three years. A high school diploma or its equivalent was all that was necessary for entry so that my college education gave me many advantages over my fellow students.

Cadavers, College

The first vacation I had at home my father questioned me about my work. I told him I was doing well except that I did not like anatomy. I saw immediately that I had said the wrong thing. He replied emphatically that I should study anatomy assiduously and that I could not be a good physician without a thorough knowledge of anatomy. When I returned to medical school I followed father's advice and applied myself to work in anatomy. Dr. Durham, director of the laboratory, rewarded me by making me assistant demonstrator. One of my duties was to receive dissecting material. It was then that I met Rufus Cantrell, a colored man who was a notorious resurrectionist. Shortly before I had met him he had burked a Chinese man. Dr. Durham refused to receive the body when he found it warm and made Cantrell take it away.

The next year Durham gave up his directorship of the laboratory and it was taken over by another M.D. who did not know his job as well as Durham. Due to some untoward happening, Cantrell and this doctor were indicted for grave-robbery. This became a front page item in the newspapers and even attracted attention in foreign countries. Cantrell liked to talk. Durham visited him in jail and told him that if he even mentioned Durham or me he would see that Cantrell was hanged for burking the Chinese man. Cantrell was sent to the penitentiary, the doctor barely escaped. The matter attracted so much attention that the next legislature passed the present law which furnishes material for the dissection room legally.

The Medical College had been recently reorganized and was headed by Joseph Eastman, Sr. The faculty included his two sons, Tom and Rilus, and several recent graduates of foreign and U.S. medical colleges so that we had very good instructors.

During my medical college course vacations father would offer my services free in obstetrical cases so that, with his help and with my work at the Bobbs City Dispensary, I had attended 35 deliveries before I was graduated. I would have attended 36 deliveries except for the following incident: Father and I had been to the country to visit a patient and on return, at the outskirts of the town, we could see two women ahead of us walking in the road. One, plainly, was about at term. Father said to me, "There's another obstetrical case I'll get for you." As we drew alongside the ladies, father stopped his horse and said to the prospect, "I see you are going to have a baby." She turned and said, "You damned old S.O.B. tend to your own damned business." Father gave the horse a slap with the lines and command to go. As we got down the road he said to me, "She didn't need to get so mad about it."

After graduation from medical college in 1902, I took an examination for internship in the City Hospital. About 40 from both schools took the examination; there were four places to be filled. The examination lasted five days. I was fortunate in getting first place with Dr. W. F. Hughes second and only five points out of several hundred between us. The hospital service was very valuable to me, especially in my contacts with the staff, most of whom were teachers at the Indiana Medical College. My salary as an intern was $12.50 a month, board and room. After I fin-

* Presented before the John Shaw Billings History of Medicine Society meeting, Sept. 10, 1969.

ished my hospital service my father came to Indianapolis to live and we opened an office together. We were able to enjoy this association about three years when I lost my father and was alone. I was frequently in contact with Dr. Pohlman, professor of anatomy at Bloomington. He persuaded me to engage in a research for the purpose of closing the patent foramen ovale in the heart of blue babies. I arranged with a student, whose preceptor I was, to care for a kennel of dogs. I went to New York City to learn the method of insufflation anesthesia and upon return we were about ready to start on heart surgery. One day I met Rilus Eastman, my most esteemed and admired surgical teacher. "Goethe," he asked, "what are you doing?" I told him all about my contemplated operation for the blue baby, my trip to New York, the dogs, etc. To my surprise he said, "You'd better get off that stuff and go to taking out the appendix or you will starve to death."

That is exactly what I did for I had the utmost confidence in Dr. Rilus Eastman and now I am sure he was right. Having turned my professional interest to appendicitis I was soon busy in that field. Many operations were done in the home then as hospital surgical facilities were not well developed. In fact I could get better and cleaner primary wound healing in a home operation than I could in a hospital—that was about 60 years ago. An operation in the home usually attracted a large crowd of observers who were permitted to line up and watch, though far enough removed from the aseptic field. One night I was doing an urgent appendectomy on the father of a family at North Salem, Ind. Mother and children were watching, together with other relatives and friends. I had entered the abdomen and was locating the appendix with the index finger and its neighbor when one of the children was heard to exclaim, "Mommy, that man's tickling daddy!"

Splendid Surgeons

I shall briefly touch upon the professional field and the individuals concerned in Indianapolis some 60 years ago. The profession was divided into two groups, their coherence and allegiance were crystallized by the organization of two so-called proprietary medical schools: The Indiana Medical College and the Central College of Physicians and Surgeons. This division of professional interests gave rise to keen competition and was also a healthy stimulus toward efforts to better scientific attainments. It also had its evils which were obliterated by the present arrangement of the educational center under university control, following the work of Abe and Simon Flexner.

The Indiana Medical College was older established and better entrenched than the other school and contained some very accomplished and strong characters. Henry Jameson, dean and a medical practitioner, had great prestige. Wm. N. Wishard was the strongest character in the school. He stood very high in the profession as an urologist but also the other group could not even approach him in management and policy. He had a large head and a powerful brain. When Frank Morrison, an eye specialist, originated some action it always made the opposition very angry but was not effective, but when Wishard directed an action it was important and fatal. J. H. Oliver was chief surgeon. He was a very likeable person and enjoyed his jokes. One morning I was in the doctor's waiting room alone at St. Vincent's when he came in. He spoke to me and said, "Goethe, I have a new treatment for postoperative vomiting, it never fails." I said, "Please tell me what it is." He said, "Ligature of the e-so-phay-gus!"

L. H. Dunning was their oldest and leading abdominal surgeon. He had taken up surgery later in life and was a very nervous operator. He was holding a clinic in the large amphitheater at City Hospital with 50 or 60 students sitting and watching when he turned around holding up a needle holder with the needle in backwards, saying: "See how my needles come!" The suture nurse burst out crying and had to be replaced. When Dr. Dunning saw what a commotion he had caused he apologized profusely and tried to make amends but apparently without much success. Tension was high; it was a very trying episode. O. G. Pfaff later supplanted Dunning in abdominal surgery.

One of the most respected and admired surgeons in this group was Dr. George Cook, inventor of Cook's rectal speculum. He did abdominal surgery also when the gastrointestinal tract was involved. He was a Kentuckian, stuttered and had a chronic cough which often interrupted when talking. One day I was walking down the street with him when he lighted a cigarette. "Dr. Cook," I said, "Don't you think cigarette smoking makes bronchitis worse?" "I don't know," (cough, cough) he said. "I never," (cough, cough) "stopped long enough," (cough, cough, cough) "to find out." End of conversation re cigarette smoking!!

There were two medical journals published in Indianapolis, one called the *Medical Monitor* was edited by Dr. S. E. Earp. The other, called the *Indiana Medical Journal*, was edited by Dr. A. W. Brayton. They were both friendly to me and helped me much by publishing my articles.

Dr. Brayton was an unusual individual and really influenced my later life. He had the greatest expanse of learning of anyone I had ever met. He knew about many things in nature. One day I was browsing in a second hand bookstore and found a book on *Birds of Ohio* written by David Star Jordan and A. W. Brayton. He was a dermatologist of high distinction, without pretense. He would read a book for scientific comparison right before the patient who then misunderstood and concluded that he was without knowledge and lost confidence in him. Among other

things he was a mushroom expert and would tell students that they were more apt to be poisoned by a potato. He caused me to abandon forever any attempt to identify and to enjoy eating mushrooms.

One spring day a group of us started to Michigan on a vacation and fishing trip. It had rained the day before and near Kokomo, looking over in a field, I saw a large clump of fresh growth mushrooms of large size. I went into the field and, though I could not identify them, there was no death cup and I gathered about a peck. That night we had a big mushroom feast. I saved one mushroom to take back for identification by Dr. Brayton. Our offices were in the same building and on the same floor. Upon return to my office I took the mushroom with me and went to Dr. Brayton's office. As he saw me coming with the mushroom in my hand he cried, "Lepiota, Lepiota"; then I told him my story. "Did all of you eat them?" he asked. "Yes," I said, "except one man." "How many of you?" I told him fifteen. "Well," he said, "they are safe, except to one out of twenty, they are poisonous." Then he told me that he had eaten a mess of Lepiota once and had almost died; that he was one of the twentieth susceptible ones. I was horrified. That terminated my interest in mushrooms as food for humans.

The Central College group was headed by Joseph Eastman. He was a renowned abdominal surgeon with an international reputation—his leading work being in hysterectomy. He had delivered the first ectopic pregnancy in the world in which mother and baby survived. He was the coolest operator I had ever seen at that time. Each year near the end of medical college session he made a talk to all classes assembled. He urged them to work hard "toward the top," for he said, "it is very lonesome up here." This was followed by loud and prolonged applause as he was highly appreciated and respected.

Joseph Rilus Eastman taught general surgery. He was one of the best teachers I have ever heard, had a foreign surgical education and used excellent English. Tom Eastman, the older son, operated with his father in their private hospital at the south east corner of Delaware and Vermont Sts. Tom was a very capable surgeon and a good teacher. He had a delightful sense of humor. One afternoon apparently after a morning of hard work I met him and he said: "Goethe, I know what I will be doing when I depart this life; the devil will put me to doing hysterectomies on fat women." He was the father of Nicholson Eastman who became chairman of the obstetrical department at Johns Hopkins.

Allison Maxwell was professor of clinical medicine and dean. George D. Kahlo, lecturer in medicine, later became head of the medical department at French Lick when it was at its top under Thomas Taggart. H. R. Allen was by far the best orthopedist in Indiana. J. H. Ford taught surgery and was Big Four Railroad District head surgeon. Albert E. Sterne was professor of mental diseases, was highly educated and a valuable teacher. Louis Burkhardt, a native Swiss, taught obstetrics. John F. Barnhill taught nose and throat. He was author of a large textbook and was the most important person in effecting the organization of the medical department of Indiana University which was to survive and thus to terminate the union of Indiana Medical College with Purdue.

A Surgical Practice

As I was one of 16 M.D.'s who supported this movement energetically and financially, when this department of Indiana University was effected, I was made director of the anatomical laboratory at Indianapolis and my story will, from now on, treat more especially of my development in the field of surgery.

I was also given odd jobs in the medical department of Indiana University such as a course in operative surgery on the cadaver. A course in genitourinary surgery, one in gynecology at the outpatient department and finally with the aid of Joe Clark I got on the City Hospital surgical staff.

Soon after I opened my office I was sitting in my office wishing for a patient when the phone rang and I was asked to come to the home of Joe Clark—he was choking to death. Joe was the political ward boss. I took my pocket case of instruments which father had given me for a graduation present, ran to the nearby stable where my horse was kept and soon was at Joe Clark's. As I entered, Joe, who was sitting in a chair fighting for breath, became unconscious. I asked one of the relatives to hold his head and I did a tracheostomy, inserting a female catheter which was in my case. With artificial respiration Joe was restored to consciousness. I then asked for a tube that I could fasten into Joe's trachea and a hard rubber vaginal syringe tip was brought to me. I cut this to the right length and it fitted perfectly. Joe recovered. He was very grateful and, as he was a powerful politician, was a valuable friend.

At City Hospital it took me several years to get across the table, but I finally got a surgical service of my own in which I did much work and gained operative facility and capacity. My private work increased apace also among which I may mention a Caesarean section, the first at the Methodist Hospital and the tenth in Indiana. A total gastrectomy for ca, the first in Indiana; the patient living for 13 years and dying of P.A. and the first caudal drainage of the pancreas for calcinosis in the world, the patient living in good health for 31 years. This operation got me into the surgical literature of the world and brought many letters from abroad including one from Moynihan, the great English surgeon.

There was a time in Indianapolis hospitals when there was no classification of service and there were



THIS picture is of the woman who had the first Caesarean section performed at Methodist Hospital by Dr. Link (possibly 1910).

medical doctors taking up surgery without proper preparation. One who was very influential in the church did more laparotomies than anyone else in the new hospital. During one of his busiest years the interns checked the records and reported his mortality for that period as 33⅓%! This could not happen today. Dr. Gatch, a Johns Hopkins pupil of Halstead, was head of the Department of Surgery at I.U. and was a very important factor in raising the level of surgery in Indianapolis and in Indiana.

During this early period in my development as a surgeon I made yearly trips to study under the great surgeons of the U.S. These included Joseph Price and John B. Deaver of Philadelphia, Morris Richardson of Boston at which time I made a lengthy visit with Reginald Fitz, John B. Murphy of Chicago and Wm. and Chas. Mayo. Thomas B. Noble of Indianapolis enjoyed teaching and welcomed me to watch his operations. I must tell you about Dr. Noble. At the time Dr. Noble was probably the busiest abdominal surgeon in Indianapolis and the most able, one of the hospitals decided to improve their record department. Among other things there was an order for better progress notes. One day, after Dr. Noble had looked over a chart and started to leave, the nurse in charge said, "Dr. Noble you have not written a progress note." "Oh," he said, "she is doing well." But the nurse insisted. Dr. Noble took the chart and wrote: "Little by little and bit by bit, God in his mercy is healing her slit." While I studied surgery constantly I felt that occasional diversion in other fields rested me intellectually and thus aided progress in my life's work.

"If We Could Walk With the Animals"

The first was an association with Carl Fisher in aeronautics. Fisher had just completed the Speedway and intended bringing the National Balloon race here as the first event in order to give the Speedway worldwide attention. I made several practice balloon flights with Fisher and Bumbaugh, a professional balloonist. Fisher and I became close friends. He was an unusual man with little education but a philosophy which placed him years ahead of the average.

The National Balloon race which I won in 1909 terminated my flying as I feared the notoriety might interfere with advancement in my chosen life's work. I shall always look back to my brief experience in aeronautics with pleasure and satisfaction and without regret. One of the pleasant recollections was meeting Wilbur Wright who came to the Speedway with his flyers and put on the second public event there.

As my surgical practice increased so did my income until I got into the bracket above 50%. When I reached a place where Uncle Sam was getting more out of a difficult operation than I, we went in the winter to Arizona for a vacation. I finally organized the Goethe and Helen Link Foundation for Scientific Research which was legally exempt from taxation when we built the Astronomical Observatory which we gave to Indiana University. My entry into the field of astronomy gave me much intellectual pleasure as it led to favorable contacts with great scientists and eventually resulted in my receiving the LL.D. and Sc.D. as well as lesser degrees.

Though we owned a home in Indianapolis we decided to buy a country place and after inspecting the country within a radius of 25 miles around Indianapolis, chose our present home which we developed into a nature center, both of us having tastes for that kind of study. Among other interesting aspects of this site we found copperhead snakes. As they are poisonous and we had a small boy, I began to study herpetology for our own protection. Like other scientific fields I found this one also interesting. When we went to Arizona or California I would visit the zoos and serpentariums. At the San Diego Zoo I found Mr. Perkins, a noted herpetologist, who informed me that

one of the leading herpetologists in the world lived in Indianapolis. When I returned home I hastened to contact Dr. Sherman Minton who has my highest regard in this field.

One winter while in Phoenix, Arizona, the following bizarre episode occurred which I believe is worth telling. The serpentarium there had recently acquired a large 15 ft. king cobra and an alligator which had belonged to Grace Olive Wiley. She was an eccentric herpetologist widely known for taming reptiles. For example she had a tame rattlesnake whom she named Huck Finn which would curl in her lap while she knitted. She had two king cobras which she carried with her in a suitcase and displayed them when she lectured. She had an alligator, tamed; the only one in the world that would come to call. Not long before the event I am relating, she had been bitten and killed by a cobra and part of her effects were now at this serpentarium at Phoenix.

One day the manager who knew I was a surgeon said to me, "Doc, what do you do for piles?" I answered that ointment could be applied but if very bad they should be removed and asked: "Have you got them very bad?" "Oh!" he said, "I don't have them—it is Grace's alligator." I said, "Why, an alligator can't have piles which are due to erect posture; an alligator is about as close to the ground as anything can get." "Well, I'll show it to you," he said as we went to the cage and he turned the alligator over. It was a tumor the size of my fist springing from the edge of the cloaca. We then arranged for removal of the tumor. The alligator was eight feet long. I had him make a trough by nailing the edge of two planks together with supports at each end. We arranged a day and an hour, with one man to be at the head and two at the tail. Mrs. Link, who had been my suture nurse, agreed to suture for me.

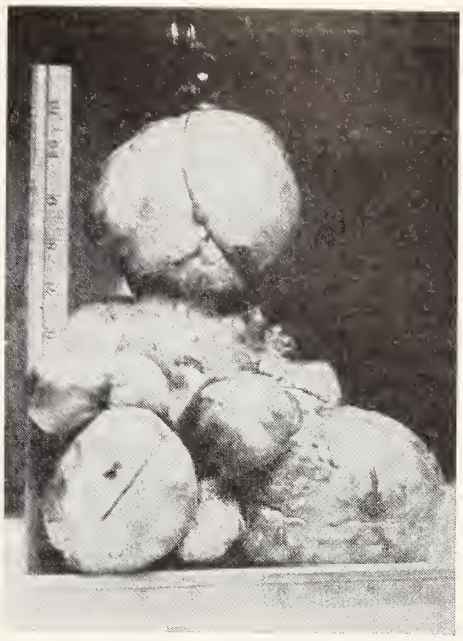


PHOTO of a huge ovarian fibroid removed from a patient by Dr. Link.

I had with me a Keith needle and catgut with which to repair my golf-shoes—these I used, together with a razor blade. I removed the tumor and sutured the wound. An anesthetic was not needed. The alligator did not move and appeared not to feel a thing. Healing occurred well and cure became complete. I took the tumor to the state health laboratory and asked the pathologist to section it. When I told him it was from an alligator he looked at me as if I were crazy. When I explained fully he entered into the unusual affair and took it for examination. It proved to be a fibroma. The experience of operating without pain and without anesthesia causes an eerie feeling which I had only once before when I did a thyroidectomy on a three-day-old baby, born with a goiter which made him unable to swallow food. He felt no pain and cooed while I worked.

My abdominal surgery continued to increase but the early work done in thyroid surgery, (I did my first thyroidectomy in 1911) brought me a gradual increasing volume in that field. I had met and defeated those who were opposed to thyroid surgery at a spirited symposium in the medical society with a result which led to my election as president of the Marion County Medical Society—the one honor in my profession of which I am proudest. I finally got so much thyroid work that I was obliged to devote all my time to it. June 28, 1926 I did nine thyroidectomies at the Methodist Hospital. I never did this again, limiting my days work to three or four and using a more meticulous technic. This field calls for most careful anatomic considerations and a preoperative preparation of the patient that does away with the need for speedy operating. In my study of wound treatment I visited every surgical service of importance from Boston to Portland, Oregon.

For the remainder of my career, especially in thyroid surgery, I adopted the teachings of Halstead: "Meticulous care and the gentle handling of injured tissues together with conscientious thoroughness and careful hemostasis."

One morning I did an especially difficult operation on a patient with a large nodular goiter. Her physician, an old doctor, followed me to the dressing room. I thought he was going to compliment me on the success of the operation. He then said, "I can't see why anyone would undertake such an operation."

The last thyroidectomy was done when I was 88 years old, September, 1967, a toxic goiter with a lipoma in front of it. She was the last of 22,043 operations, the last 2,043 without a death.

My present hobby and study is in the field of ornithology, with especial emphasis upon the ruby-throated hummingbird of which I have a colony of 40 or 50 birds consuming 78 pounds of sugar in one season. You are all cordially invited to come to see them at Tanager Hill.

Dr. Goethe Link--Herpetologist

SHERMAN A. MINTON, Jr., M.D.
*Indianapolis**

ALWAYS an enthusiastic naturalist, Goethe Link dates his specific interest in herpetology to early days at his present home at Tanager Hill in Morgan County. His first concern was with the possible danger to his family from the copperheads that frequented the hilltop. Characteristically, he set about to learn as much as he could about the copperhead, both from reading the scientific literature and from direct observation. He captured copperheads to learn of their behavior in captivity and dissected wild-caught snakes to determine their feeding habits and reproductive cycle. Many of his specimens and notes were sent to Howard K. Gloyd, then of the Chicago Academy of Sciences, who has for some years been gathering data for a monograph of *Agkistrodon,* the genus of pit vipers to which the copperhead belongs. He also supplied me with live copperheads for some of my work on snake venoms.

Herpetology is the study of reptiles and amphibians, not, as many believe, solely the study of snakes. Like some other financially unremunerative subspecialties of zoology, it depends to a large extent upon the work of amateurs and part-time professionals. Partly because of the fascination exerted by snakes and some other reptiles, herpetology attracts a good many followers, some of whom have made notable contributions. The amateur who adheres to professional standards is particularly beneficial to biology, for he often brings a fertilizing element of originality to his work. The late Laurence M. Klauber, by profession an engineer and corporation executive, was one of the leading American herpetologists of this century and one of the first investigators to apply statistical methods to taxonomic problems. One of Israel's outstanding herpetologists is J. H. Hoofien, a bank executive.

Many of the early herpetologists were medical men largely because the only education in zoology available a century or so ago lay in the preparation for a medical career. Moreover, the physician, with his background in anatomy and physiology, was often predisposed to turn to one of the biological sciences for an avocation. The first scientific work on Indian snakes was published about 1800 by Patrick Russell, a physician with the East India Company. He was the first of an unbroken line of British physician-herpetologists whose contributions to knowledge of the reptiles of India and southeast Asia continued into the twilight of the British Raj. The three volumes on reptiles in the *Fauna of British India* series were written by Malcolm Smith, former Court Physician to the King of Siam.

The first comprehensive account of the amphibians and reptiles of the United States was the work of a South Carolina physician, John Edwards Holbrook. The first edition of his *North American Herpetology* appeared in 1836 and is comparable to Audubon's great works on the birds and mammals of the continent. Pioneer work on the chemistry and toxicology of snake venoms was done by S. Weir Mitchell, the noted neurologist and novelist. Howard Kelly, distinguished surgeon and professor of obstetrics and gynecology at Johns Hopkins, had a lively interest in snakes and coauthored a book on the snakes of Maryland. The late Frederick A. Shannon, an Arizona surgeon, was a leading authority on the herpetology of the southwestern United States and Mexico. About a half dozen American physicians are now actively working in herpetology, and a number of others maintain a tangential interest because of their concern with snakebite.

An Inherent Inquisitiveness

In the course of his reading on the occurrence and distribution of venomous snakes in Indiana, Dr. Link encountered an 1892 report of a coral snake collected near Milan in Ripley County. He located and identified the original Indiana specimen in the biology collection of Evansville College. A. J. Bigney who described the specimen and Henry F. Bain who collected it were both dead, so the circumstances of its discovery could not be determined. Dr. Link's investigation of this and other northern records of the coral snake is the subject of a paper in *Natural History Miscellanea* for December 14, 1951. Attempts by several herpetological collectors to turn up additional coral snakes in southern Indiana, Ohio, Kentucky and Illinois have been unproductive, and it is impossible to say whether the Milan snake was a waif or the last known individual of a natural population.

Dr. Link's initial interest in copperheads and other poisonous snakes soon extended to the less sinister amphibians and reptiles found near his home. To date 14 species of amphibians and 11 species of reptiles have been recorded from Tanager Hill, and specimens have been deposited in major museum collections.

During the late 1940's and early 1950's the Link family vacationed in Arizona where Dr. Link broadened his herpetological experience both by field observations and by contacts with local scientists interested in reptiles and venomous animals. For

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several years he was in contact with Herbert L. Stahnke and his associates at Arizona State University and advised them on some of their research on scorpions and poisonous snakes. Southwestern reptiles such as gila monsters and horned toads found their way to Tanager Hill, while Indiana snakes and salamanders were sent to herpetologists in Arizona. During the summer of 1950, we were temporary custodians of the Link's gila monster while they were on holiday. On one of his visits to a reptile exhibit in the southwest, Dr. Link was asked if he could do anything for "an alligator with hemorrhoids." The saurian's hemorrhoids turned out to be a cloacal tumor that was removed successfully. As an honorarium for this operation, Dr. Link was given a large box of photographs, notes, and scrapbooks that had belonged to Grace Olive Wiley, a remarkably skillful but eccentric snake keeper who had died a few months previously from the bite of a cobra.

Reptilian Repository

In 1955 the Link family's wanderings took them to the Big Bend country of Texas where my family and I were spending a sabbatical leave. We spend several days introducing them to the plants and animals of that remote and interesting region. One evening Dr. Link and I hiked up a little canyon that was habitat for the uncommon Trans-Pecos copperhead and also held a large spring that was the source of our totally untreated water supply. In a pool below the intake pipe floated a large dead skunk! As I recall, neither of us said much about the incident, but we all switched to soft drinks for the rest of the visit.

For a number of years, Dr. Link was a member of the Herpetologists' League and the American Society of Ichthyologists and Herpetologists, the two leading professional societies for students of reptiles and amphibians. He acquired a fine herpetological library, concentrating particularly on works dealing with poisonous snakes and their venoms and with the distribution of reptiles in the United States. It was in the Link's home that I first became familiar with such works as Phisalix' *Animaux Venimeux et Venins* and Kraus and Werner's *Giftschlangen und die Serumbehandlung der Schlangenbisse*, books not likely to be selected by a dilettante.

Like most herpetologists, Dr. Link has done his share to educate the public about reptiles and dispel the misconceptions that continue to accumulate about them. Through popular articles, lectures, and informal talks, he has reached many groups. People often bring snakes and other reptiles to him for identification. He has made Tanager Hill a place where parties of youngsters sponsored by the Indianapolis Children's Museum can learn something of amphibians, reptiles, and other wild creatures in their native surroundings.

For Goethe Link, herpetology is but one facet of a brilliant and versatile career. He has pursued it with abounding energy and intellectual curiosity, and his contribution has earned him the respect and friendship of his peers. In a world that is only beginning to appreciate the complexity of the environment man shares with other living creatures, we need more men of his breadth of knowledge and zest for learning. ◄

AMA Offers "No Smoking" Signs

Growing numbers of non-smokers are objecting to the gratuitous pollution inflicted upon them by tobacco users. To avoid possible confrontations between the two factions in physicians' reception rooms, the American Medical Association is offering desk-top signs and wall plaques; the former asks "NO SMOKING PLEASE" and the latter announces, "For The Sake Of Your Health And The Comfort Of Others—No Smoking Please." Sign prices are 95¢ each for five or more, and $1.25 for up to four signs; the plaques are $1.50 each up to four, and $1.20 for larger quantities. Orders from medical societies enjoy a 50% discount.

Dr. Goethe Link--Technic of Thyroidectomy

FRANK B. RAMSEY, M.D.
Indianapolis*

A talk with Dr. Goethe Link is like a front row seat for one of the great events in the history of medicine—the history of thyroid surgery. He was a pioneer in the surgical treatment of thyroid disease and has participated in every new development, and many times was the innovator for, the refinements which have made thyroidectomy one of the most effective and also one of the safest of operations.

Dr. Link was a busy, successful and well-trained general surgeon when thyroidectomy was pioneered by Kocher. His work in abdominal and gynecologic surgery was attested to by his having performed the first total gastrectomy in Indiana, with a favorable result, and by performing one of the early Caesarian sections. His classical work on caudal pancreatostomy has been the No. 1 reference for years for those who write on pancreatic lithiasis.

During his early years in practice he was the unintentional beneficiary of being assigned, as a part of his teaching position in the medical school, to the section of head and neck anatomy. At that time the study of head and neck anatomy had very little significance in medicine and surgery. Its study was akin to the pure basic research of today. It was not capable of practical application and pursuit of its intricacies was actually an intellectual exercise.

Dr. Link, true to what is now recognized as his lifelong custom, adopted a hobbyist's interest in anatomy and pursued its mysteries to the ultimate. By accepting what was apparently a dreary task, he acquired a knowledge which was to be indispensable in the development of thyroid surgery.

* Editor of *The Journal*.

And so it was, in 1911, that Dr. Link began his career in surgery of the thyroid gland with a dual foundation of consummate skill in general surgery and an intimate knowledge of the anatomy involved.

Many thyroidectomies in that day were indicated by hyperthyroidism. Operation was frequently resorted to in desperation after long delay; the patients were poor surgical risks because of long-standing toxicity and its complications. Since this was in the pre-iodine era, there was no medical treatment of a specific nature that was of much avail. Dr. Link contributed greatly to the cure of hyperthyroidism by his adoption and development of thyroid artery ligations as staged procedures preparatory to later and eventual thyroidectomy.

Early Collaboration

Also, during this era, Dr. Link adopted what was later and still is the universal custom of collaboration between medical and surgical disciplines for preparation of the toxic patient. This is a common phenomenon today in all sorts of serious illnesses. Then it was uncommon. The custom has grown and prospered, at least in part, due to its outstanding success and demonstrated efficacy in the crises of hyperthyroidism.

Early in his work in thyroid surgery, Dr. Link and his medical confreres observed that the natural course of hyperthyroidism was intermittent and that even without treatment, and at times in spite of it, the patient achieved periods of remission during which surgical procedures were better tolerated.

All these early observations and innovations prompted Dr. Link to adopt a fundamental rule for hyperthyroidism. The rule has been stated in various ways and by many others since then, and still remains the one basic and most important consideration. Simply stated it is: Never operate on a toxic patient until maximum improvement has been achieved and never do more of the operation than the patient will tolerate safely.

Application of the rule, of course, depends on good clinical judgment and the willingness to spend whatever time and patience is necessary for the rehabilitation of the patient for operation. The introduction of preoperative iodine feeding and, later, the advent of antithyroid drugs had made the tasks of the therapeutic team considerably easier, but has not invalidated the basic rule even to this day. Dr. Link, to his honor and distinction, was early one of the foremost proponents of the rule and one of its most devout practitioners.

His teaching of the importance of gentleness in the handling of tissues and the necessity of meticulous hemostasis in thyroidectomy was the result of his early experience. His demonstration of the difference in size of the superior and inferior thyroid arteries and the conclusion that the flow was about ten times as great in the inferior artery was one of his original contributions to the art. The fact that the predominant vessel was the most difficult to tie did not discourage him. He devised an incision which enabled him to tie both upper and lower arteries under local anesthesia.

Dr. Link appreciated the biological rule that glandular tissue when removed to excess will regenerate in response to bodily requirements if it has an adequate blood supply. He ligated the superior vessels outside the gland but, except in cases which required preliminary artery ligation,

he tied the inferior branches on the cut surface of the gland remnant—thus preserving blood supply to the remnant and to the parathyroid gland. This method produced euthyroidism and insured normal thyroid function later in accordance to Dr. Link's statement that his mission was to correct the thyroid function immediately and to maintain it at normal for the next 30 years or more.

His latter professional life was spent in the thyroid field because he became so engrossed in it that there was no time for general surgery. His thorough and painstaking dedication to the surgical treatment of thyroid disease exemplifies the characteristic which rules his life, his vocation and many avocations. Everything Goethe Link was ever interested in was followed to the limit of his ability. His interest in nature is unbounded. He never did anything halfway. ◀

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Up to 25 complimentary copies of the 10-page pamphlet will be provided on request to medical societies and individual physicians for selective distribution. All inquiries should be directed to the Communications Department, The American College of Obstetricians and Gynecologists, 79 W. Monroe, Chicago, Illinois 60603.

Dr. Goethe Link--Ornithologist

DOROTHY WHITE
*Indianapolis**

DR. GOETHE LINK has been a member of the Nature Study Club of Indiana and the Audubon Societies, national, state and local, for many, many years. He has contributed to our programs, both written and oral, and he has acted as a member of the governing board of the Nature Study Club of Indiana.

At least once a year, the Nature Study Club of Indiana has been invited to the country home of the Links, Tanager Hill, to enjoy the out-of-doors and hospitality of Dr. and Mrs. Link. Dr. Link has long been interested in birds and bird-life. He trained a red-breasted nuthatch to eat melon seeds from his hand and the chickadees, too. One red-breasted nuthatch uttered "peep" on alighting on his hand and in this way got his name. Another said "peep, peep" and was named accordingly. A larger one and one that the other birds seemed afraid of was dubbed "Peep's Uncle."

All the woodpeckers native to Indiana eat food from his feeders; the cardinals, too—their choice of food being sunflower seeds. The chipping sparrows, marked by white eyebrow stripe and rusty cap, come to eat crumbs from a hollowed-out rock on the terrace.

Welcomed and Protected

Not too far away are bluebird houses and flicker boxes, where broods have been hatched and protected. A huge martin house has been erected on the grounds and has been occupied for years. Because of this, there are fewer mosquitoes and other damaging insects in the area. The clear call of the meadowlark can be heard not far away and in the summertime, as soon as dusk comes, the whippoorwills' almost constant song is in the air.

The owls, too, are in the evergreens in the woods nearby. It goes without saying that the flycatchers, kingbirds, phoebes, wood peewees, golden and ruby-crowned kinglets, tufted titmice, brown creepers, robins, wood thrushes, brown thrashers, catbirds, mockingbirds, cedar waxwings, wrens, vireos and all the warblers are about and welcome. Kingfishers, jays, orioles, finches, towhees and, of course, the scarlet and summer tanagers know they are protected here. Thus Tanager Hill was named —a friend to all these and more.

Dr. Link became especially interested in the ruby-throated hummingbird (Archilochus colubris). These birds are found in the new world only and the only ones east of the Rocky Mountains are the ruby-throats. They are only 3-3½ inches in length, the smallest of our birds. The iridescent gorget or throat patch of the male is brilliant red in the sunlight. His mate has white tips on her outer tail feathers and a white throat. She is a bit larger than her mate.

Dr. Link has designed a feeder himself just for these tiny feathered friends. He uses hardware cloth as a cover over squatty bottles and fills them with sugar water. They hang from a central stem and spread around in a circle-like pattern. A few or many bottles can be hung from the central stem. As the birds increase in number, Dr. Link puts out more bottles. I have seen as many as 26 hummingbirds sipping at one time, although their flight is so fast it is hard to count them. It is a delight to watch them come and sip and fly away. Where? It is difficult to find the nests.

Only a few "birders" have seen the ruby-throats' nest and fewer have ever found one. As soon as the blossoms containing the nectar appear, the ruby-throated hummingbird appears. Their winters are spent in central Florida and southern Louisiana, south through Mexico to Panama.

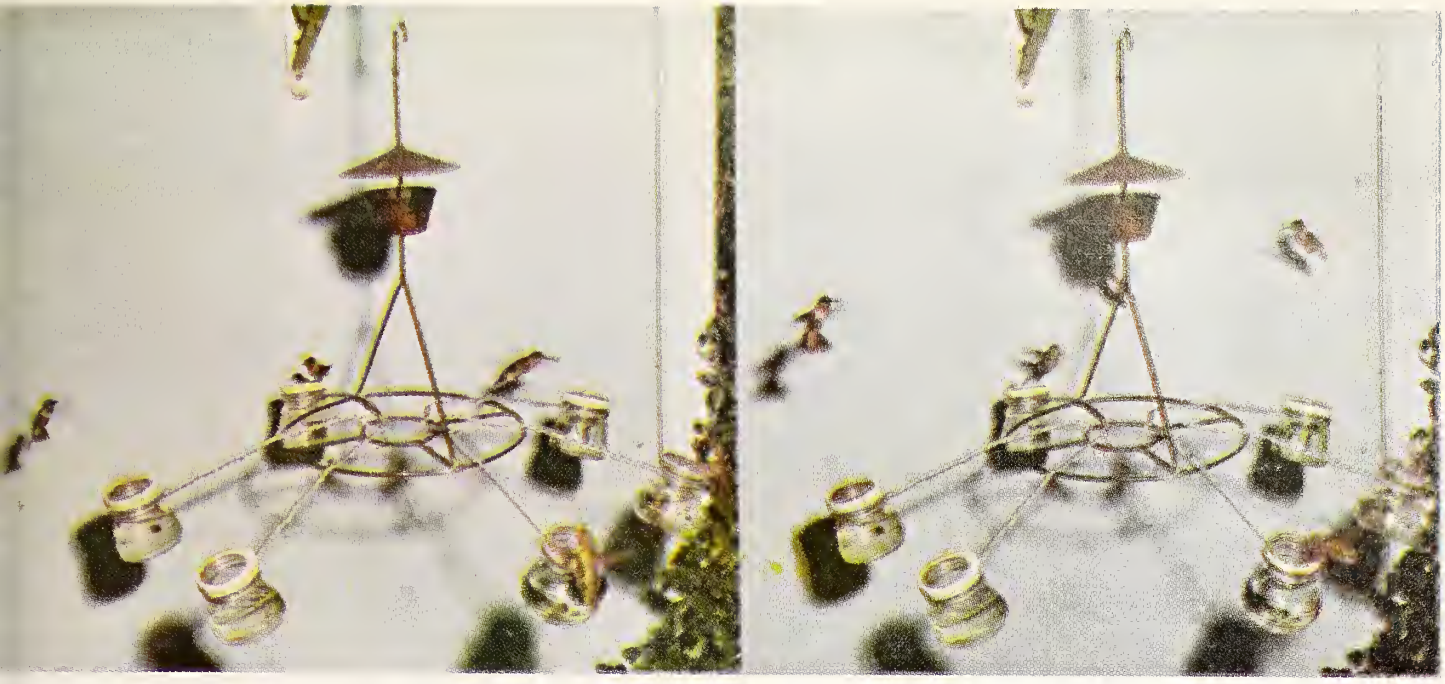
The hummingbird is the only bird that can fly backward, forward, up and down, a veritable helicopter, hovering as it sips the sweet liquid. Its protein food consists of small insects. The nest is about 1½ inches across, made of lichens, spider webbing and the down of plant seeds. This smallest of all birds has a rapid wing-beat—55-75 times a second. It has no song, but a jabber of high-pitched squeaks comes from this species.

"Man of Many Carriers"

Dr. Link has studied, watched and listened to these birds so carefully that before he arises in the morning, when they come outside his window, he can tell one from another by their sounds. In flying, the beats of their wings are so rapid that only a blur is visible, and a humming or buzzing sound is produced. They lay only two white eggs, the size of a large pea or a Great Northern bean. Perhaps the most remarkable feat of the hummingbird is hovering motionless in the air while sipping nectar from flowers and feeders.

The wing structure is different from other birds in that it moves

* Miss White is a past-president of the Amos W. Butler Audubon Society.



THE hummingbird feeder which Dr. Link designed himself.

from the shoulder with a swivel joint; and on the backstroke, the entire wing swivels almost 180 degrees. The ruby-throated hummingbird weighs three grams or about 150 birds to the pound.

All this knowledge and information Dr. Link has observed and in his generosity, shares this knowledge with us and with anyone who travels to Tanager Hill. Alert and active today, Dr. Link's life has been made fuller and happier by his many interests, not only in people, but in everything round about—a "man of many carriers" he has been called. ◄

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Dr. Goethe Link--Surgeon

JOHN H. MULHOLLAND, M.D.
New York, N.Y.*

I am pleased that Doctor Austin Gardner invited me to participate in this tribute to an extraordinarily gifted Hoosier, Doctor Goethe Link.

My qualifications for this privilege are slim. I have not met Doctor Link. My knowledge of him is not on the basis of his accomplishments as an astronomer, ornithologist, herpetologist, baloonist, or raconteur, but as a surgeon. And that knowledge derived from one significant paper of his published in the June, 1911, *Annals of Surgery* (a journal with which I am associated) on the subject of chronic pancreatitis, a disease in which I have been interested.

The title of Doctor Link's paper is "The Treatment of Chronic Pancreatitis by Pancreatostomy: A New Operation." It is a well-written, nicely illustrated, 14-page article based on the operative treatment of a young woman patient who had severe calcific pancreatitis, a condition which would challenge an experienced surgeon now, 50 years later.

From introductory comments in the article, one could judge that operative surgery on the pancreas was recognized as being hazardous and without great promise of relief or cure. Von Mikulicz, the noted German surgeon, is quoted as saying that operations on the pancreas are much more dangerous than operations on any other organs; that hemorrhage is difficult to control; that necrosis is caused by deep sutures; that there is great danger of fat necrosis by leaking pancreatic secretion. The operations von Mikulicz performed to establish his judgments were for cancers of the stomach extending into the pancreas, for cysts and tumors but never for perplexing chronic pancreatitis. Accepted operative treatment for chronic pancreatitis was simple cholecystostomy. At that time the diagnosis of inflammatory disease of the pancreas was almost always made at an operation performed for what was thought to be another disease and the pancreatic lesion found would necessarily be advanced.

Intuitive Reasoning

Such was the case in Doctor Link's young patient. She was emaciated and anemic and was thought to have some disease of the stomach, probably malignant. She had severe abdominal pain in attacks which progressively became worse and more frequent. Because her girdle-like pain at times radiated down the left side and ureteral catheterization indicated a lesion of the left kidney, Doctor Link left a catheter in the left ureter and exposed the left kidney through a lumbar incision. He found that the lesion was extra-renal, and "in relation with kidney, a peculiar pointed object which felt like a bag of fine sand," was recognized as the tail of the pancreas. The lumbar incision was closed and an anterior abdominal incision made. He opened the mesocolon, mobilized the stone-filled pancreas and delivered the tail of the organ through the mesocolon. The dilated main pancreatic duct on its surface was then split throughout its length to empty it of calculi. A drainage tube was placed in the stone-freed gutter and the gland was sutured over it. The tube was then brought out through the abdominal wound.

Doctor Link's description of the operation is as modern and fresh as a new sunrise. Although he "then quietly awaited the patient's certain death" from some of the dangers von Mikulicz warned about, she recovered smoothly. Pancreatic juice drained from the tube in decreasing amounts and after gaining 30 pounds, she enjoyed "riding horseback and social mingling."

What a triumphant combination of technical skill and sharp judgment! The dynamics of thought involved in this act are characteristic of a scientist. In spite of authoritative warnings and admonitions of hazards, the operation was carried out on the basis of his intuitive reasoning. Other scientist surgeons in later years who did not know of Link's work but who had much more background information than he had rediscovered almost precisely the same technic. This is a modern operation.

In his discussion of the case Doctor Link pointed to other features which have since been shown to be fundamental in what understanding we have of this baffling disease. He commented on the proximity of the tail of the inflamed and swollen pancreas to the left kidney and the likelihood of renal function being impaired. It is now known that pancreatitis can be the source of perinephric abscess in an otherwise normal kidney.

He remarked that the hemorrhagic tendency which was at that time assumed to accompany and be due to pancreatitis was not observed in this patient and that hemorrhage was more likely due to jaundice which was generally a component of pancreatitis, but which did not occur in this patient. We know now the truth of his surmise.

* Chairman, Department of Surgery, Third Surgical Division, Bellevue Hospital, and editor, *Annals of Surgery*.

He remarked also that the gradual eduction in amount of pancreatic uice draining through the wound was not due to a decrease in the ecretion, but to the fact that the ancreatitis subsided and that as the swelling of the gland became reduced, greater portion was allowed to scape by the normal way." This lictum was reached without benefit f serial secretin tests, enzyme determinations, selective angiograms r radioactive isotopes.

What is perhaps most revealing of Doctor Link are comments he made n his 1969 address to the Billings Society: "In my study of wound reatment I visited every surgical ervice of importance from Boston o Portland, Oregon. For the remainder of my career I adopted the eachings of Halstead, meticulous are and gentle handling of injured issues together with conscientious horoughness and careful hemostasis." Maybe that is why von Mikulicz's catastrophes did not follow Link's operations on the pancreas.

One might wish that this Leonardo-like man who is blessed with so many ucid years of life had wielded his prodigious faculties in other areas of gnorance in medicine and surgery, but it is enough now to wish him good sugar for his ruby-throated hummingbirds. ◄

THE TREATMENT OF CHRONIC PANCREATITIS BY PANCREATOSTOMY.

A NEW OPERATION.

BY GOETHE LINK, M.D.,

OF INDIANAPOLIS, INDIANA.

Assistant Professor of Gynæcology in the Indiana University School of Medicine.

THOUGH chronic pancreatitis was recognized post mortem many years ago, it was not found in the living until 1891, when Robson [1] observed the enlarged pancreas while doing a cholecystotomy. His first cases were mistaken for malignancy, but recovery showed the condition in its true light. In 1892 he was able to demonstrate the nature of the enlargement by microscopic examination. The development of surgery of the bile passages has led to much of our present knowledge about pancreatitis, as it is found frequently at operations for gall-stones.

The importance of chronic inflammation of the pancreas as a complication of gall-stone disease has been emphasized by a number of investigators. W. J. Mayo,[2] in calling attention to pancreatitis resulting from gall-stone disease, reported that he had found the pancreas involved 141 times in 2200 operations on the gall-bladder and biliary passages. Of all pancreatic diseases operated by Mayo, 81 per cent. were "due to or accompanied by gall-stones." Most observations regarding chronic disease of the pancreas have been made by operators interested in liver surgery, and operations have usually not been undertaken until biliary disease, if it were not the cause of the pancreatitis, had become a complication of it. Though it is a well-established fact that disease of the bile passages is the most common cause of pancreatitis, it is also true that the pancreas is sometimes the point of origin of disease, and through its anatomic relation with the common duct produces jaundice and other biliary disorders. It is significant that in Robson's first cases of chronic pancreatitis, jaundice

ORIGINAL title page from a reprint of Dr. Link's article on "The Treatment of Chronic Pancreatitis by Pancreatostomy", Annals of Surgery, June, 1911.

Dr. Goethe Link--Aeronaut

PETER KRIEG
*Indianapolis**

"WHEN we crossed the Ohio River it was just beginning to get daylight. We had no more than crossed the river than they started shooting at us with shotguns. I knew that they couldn't reach us with the shotguns as we were about half a mile high then, but finally some fellow took a shot at us with a rifle and when he did that we went up two miles high and we were about two and a half miles high the next time we saw Coey. He was I judged, about fifteen miles in back of us and Irwin was sitting down in the bottom of our basket and we were nearly three miles high by then, blue in the face, we didn't have much oxygen . . . ."

The year was 1909, the speaker was Dr. Goethe Link describing his part in the National Balloon Races which were started from the Indianapolis Motor Speedway. The Indianapolis, one of nine gas balloons which ascended that cloudless day of June 5, was to be piloted by the thirty-year-old Dr. Link with J. R. "Russy" Irwin as aid. Other notables included Carl Fisher, promoter of the race and Capt. G. L. Bumbaugh in the balloon Indiana, Col. C. A. Coey in the Chicago, Capt. T. S. Baldwin flying the Hoosier and other aeronauts in the New York, the St. Louis, the Cleveland, the University City and the Ohio.

"Riding the Air"

Dr. Link first became interested in aviation and aeronautics from a theoretical standpoint. "I used to watch the soaring birds from my grandfather's farm and try to discover how they soared. I was never able to discover it because the birds didn't move. I didn't know they were riding an ascending current of air because I couldn't see the air."

When Carl Fisher first built the Speedway, he wanted something to promote it so he got a balloonist by the name of Bumbaugh to come here for that purpose. According to Dr. Link, "Bumbaugh had no formal education, but he had been in Europe and France where they were interested in aerostation and he knew how to make a balloon and how to fly one. I got acquainted with Carl Fisher and when he found out I was interested in ballooning, he would take me with him on the flights and from this man (Bumbaugh) I learned the practical art of flying a balloon. We flew from the gas plant on Northwestern Avenue during these training flights."

So Goethe and his friend Russy Irwin decided to enter the balloon race. They bought a balloon and the equipment from Capt. Bumbaugh, and Carl Fisher had a gas main run all the way out to the Speedway from the gas plant just to fill the balloons. The night before the race, Dr. Link was privileged to spend two hours with Major Hershey of the U. S. Weather Bureau. Hershey was an avid balloonist himself and was well known in aeronautic circles for his accomplishments. Hershey liked the doctor from Indianapolis and explained in detail the scientific aspects of aerostation and the fine points of flying a balloon. Major Hershey's help was a large factor in Dr. Link's victory.

The afternoon of the race found massive traffic jams on the roads leading to the Speedway. Inside the oval, where admission was $1.00 for spectators, the balloon crews were busily readying their craft for the race. Dr. Link and Mr. Irwin would be flying the Indianapolis in the handicap race as she was of 40,000 cubic foot capacity, lacking the 80,000 cubic feet necessary for the championship race. Sixteen sand bags of 40 pounds each were tied around the basket as ballast. This sand would later be slowly released by Link as required to maintain elevation during the trip.

Shifting Sand

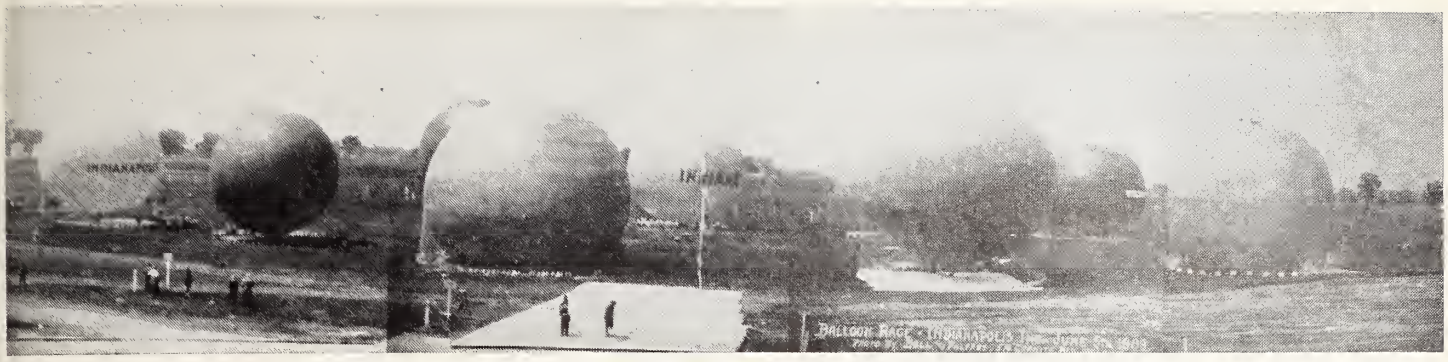
Releasing sand from a gas balloon in flight requires a great deal of judgment. If too much is released at one time, the balloon will ascend to a point at which it will start losing gas because of the decreased atmospheric pressure surrounding it. As this happens it also becomes less bouyant and a descent is then started. If more sand is not released immediately to check the descent, the balloon will gain momentum in a downward direction and crash unless great quantities of sand are released before it hits the ground. If the balloon is allowed to rise and fall radically, gas and ballast will be used up in a short time and the total time that the balloon can remain aloft will be greatly diminished.

The objects of this race were twofold—to travel as far as possible and to remain in the air as long as possible. "Every bit of sand went out of that balloon between my fingers," quips Dr. Link. Additional equipment taken aloft by the Indianapolis included a 300 foot long trail rope, various articles of clothing, a few instruments and the necessary food and water.

The Indianapolis was one of the first balloons to ascend and after drifting southward for several hours, it was engulfed in darkness. The race was planned to take advantage of the full moon and the reflection from the ponds and rivers was quite impressive to the nocturnal aeronauts.

In those days balloon races continued on through the night and into the next day if the pilot was skilled enough to remain aloft for that long. Dr. Link relates, "I remember riding over southern Indiana over a forest.

* President of the Hot Air Balloon Club of Indiana and winner of the 1969 Balloon Race at the 500 Mile Track.



ORIGINAL photograph of the 1909 balloon race at the Indianapolis Motor Speedway.

and there was a house in the middle of this forest. We were just barely skimming over the tree tops and our drag rope, which was 300 feet long, was out. I remember dragging that rope over a tall forest tree and when it got over the tree it hit that house —you could have heard it for a mile. It was getting close to midnight and I wondered what those people thought it was."

After crossing the river the next morning and being shot at, our itinerant aeronauts thought it best to ascend to the startling height of two and one-half to three miles. At this altitude the air was quite thin and cold and this caused the shivering Russy to utter "If I ever get out of this alive, I'll never do this again." Well, Russy stuck it out long enough for the Indianapolis to beat Coey in the Chicago by about 15 miles and they landed north of Gallatin, Tennessee, near Westmoreland in a garden after having to throw their lunch basket out to lighten the load at landing. It was Sunday morning and a large crowd gathered at the site to inspect the foreigners. At this point one of the natives remarked, "You all come pretty near getting shot back there." At Dr. Link's urging he continued, "Bill and I was out in the yard and saw you comin' and I said 'There's somethin' alive in there' and Bill said, 'No they ain't.' 'Well, I said, I'll just go in and get my gun and we'll find out.' By the time I got back out in the yard, you had come down behind that woods over there and I couldn't shoot at you." That's the way it was in Tennessee.

"Gourmets" Aghast

Our adventurers were quite hungry by this time and having discarded their lunch basket, they inquired about a place to eat. They were taken to a hotel where they were offered a pan of turnips floating around in grease and graced with a few dead flies which had had the first helping. Evidently Russy couldn't stomach the whole thing so they made up some excuse and got away. Several locals gratefully walked back along the path of the balloon and recovered the lunch basket which was relatively intact after being dropped. But alas, when the hungry pair opened it, it was full of ants. "We weren't any better off than with cooked flies." Russy was kind of sore about the happenings in Tennessee and he referred to the natives as "heathens," but not too loudly for fear of riling up one of the rifle-toting farmers.

After spending the night in town and having hard boiled eggs for breakfast the next morning, the pair packed up and returned to Indianapolis but not before Dr. Link telegraphed a story to a friend on *The Indianapolis Star* which later gained international circulation via the Associated Press. They had placed first in the handicap event in both distance and time aloft and had an engraved sterling silver cup to show for it. For the doctor and Russy to have beaten Coey in the giant Chicago and won the race seems even more incredible when one considers that they were both relatively novice aeronauts and they were competing against a balloon which held 100,000 cu. ft. of gas as compared to theirs which contained 40,000.

For the other contestants there were really no major mishaps. All got off the ground well and headed in a southerly direction. Two came down quite early in the race and never got out of Indiana while Carl Fisher disqualified himself because he and Capt. Bumbaugh alighted in Tennessee to exchange some bad drinking water which they had taken aloft and Fisher decided to disembark from the balloon to smoke a cigar. To do this he had to step onto the ground and walk way from the balloon a few yards to insure against igniting the 80,000 cu. ft. of cooking gas in the balloon. He later said it was a good cigar, even if it did cost him the race.

Old Balloon Men Don't Forget

Sixty-one years later Goethe Link fondly recalls this race and the details almost as if he had flown it yesterday. As a matter of fact, that race marked the last time the doctor ever flew in a balloon. He felt that to con-



DR. LINK presented the cup he won in the 1909 balloon race to Dr. Paul Garber, of the Smithsonian Institute, in April of this year.

tinue ballooning would endanger his professional standing as a surgeon because of the attention it drew. Ballooning is and was an avocation which was sometimes looked upon by the general public as open only to daredevils and circus stunt men; in 1909 it was not practical to practice medicine and be an aeronaut. Actually balloons have been used since their inception for scientific, military and serious sporting purposes as well as to attract crowds to county fairs.

But old balloon men don't forget and they are as willing to slip back 60 years into the past to recall bygone days as they are eager to learn of the rebirth of ballooning in the form of the modern propane-fired thermal balloons which have recently taken to the air. Goethe Link is an old balloon man and is one of those rare breed whose interest and enthusiasm transcend the generation gap and span the years. Those of us in the ballooning fraternity in 1970 welcome Goethe Link with open arms; may he be with us until the last balloon fades from sight into the setting sun—many eons hence. ◄

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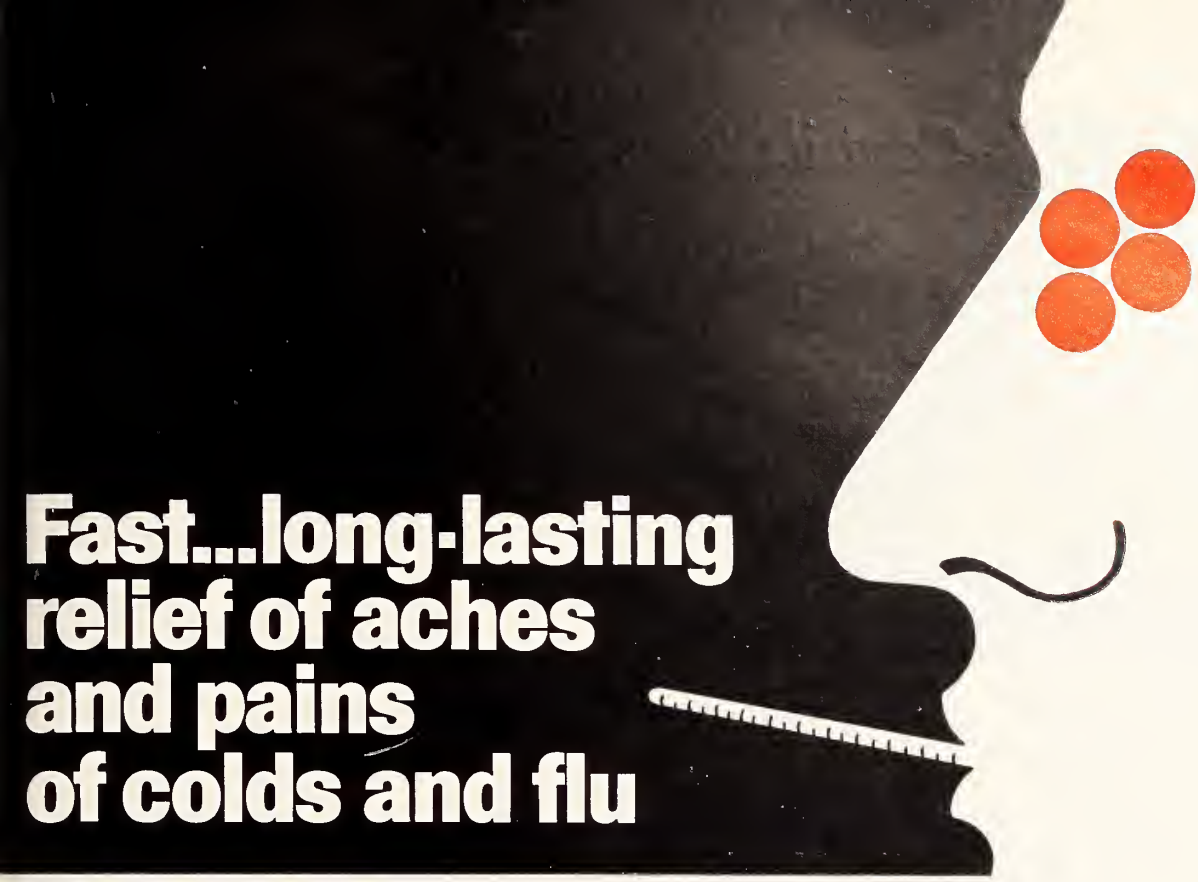
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Dr. Goethe Link--Contributions to Internal Medicine

ARTHUR B. RICHTER, M.D.
Indianapolis*

FOR me to say a few things about Dr. Goethe Link's contribution to internal medicine and to give honor to this great man is indeed a privilege.

Dr. Link is a scientist, physician and surgeon. He does not consider his long career in surgery of the thyroid gland has contributed to the field of internal medicine. Contrariwise, he states it is the internist who gave him the support so necessary to the preparation and care of the patient so that he could exercise his surgical skill. He is most generous in this response since he once published a paper in this *Journal* on the management of medical complications of goiter (1940). There are three internists whom he regards most important in his career—Dr. Albert C. Kimberlin, Dr. Robert M. Moore and myself.

Dr. Link was basically a self-made surgeon. He had a good fundamental college education before medical school, a good knowledge of human anatomy, a critical research approach to all problems with honesty in purpose and in his thinking. His courage has been evident in new operations, firsts or near firsts. His initiative, curiosity, and energy took him into some fields of natural science. Such intellectual versatility has seldom been shown by a practicing physician.

He was a superb abdominal surgeon. This type of surgery was gradually pushed aside by the demand of increasing numbers of goiter operations. He has done 22,043 operations on the thyroid. The last operative death, in 1942, was due to mediastinal infection which might have been cured had penicillin then been available. Since then he has done 2,043 consecutive operations for goiter without a death. This wonderful record extends far back to the more difficult days before thiouracil (1946), propylthiouracil (1947) and radioactive iodine (1942). He has a record of every operation, all types, thousands of them, since he started practice.

So far as I can ascertain, Dr. Link did the first operation on the thyroid gland in Indiana in 1911. Kocher was the first to excise a goiter in 1878; he was operating on endemic nontoxic goiters. Like most pioneering in surgery, Dr. Link's first patients were very ill with hyperthyroidism. In 1948, when he was 69, Dr. Link reported in this *Journal* 1,200 consecutive operations for goiter without a death. At that time Dr. Frank Lahey had a sequence of 1,600 cases between deaths. This demonstrated safety of thyroidectomy is due to the development of better antithyroid drugs and iodine; however, the skill, good judgment and experience of the surgeon cannot be minimized. After the usual age of retirement Dr. Link did 843 thyroidectomies with no deaths!

In 1903, Dr. Link, at the age of 24, started practice in Indianapolis associated with his father, William H. Link. He died three years later at age 55. Like his father, he did general practice and surgery. William H. Link had practiced in Petersburg and did his operations in the home. He was one of the first surgeons in Indiana (1900) to use asepsis. He moved to Indianapolis to open an office with his son. Goethe continued to teach gross anatomy in the Indiana Medical College, where he was director of the gross anatomical laboratory. Sixteen physician part-time teachers from the Indiana Medical College (Purdue) and the Central College of Physicians (Indiana) formed the State College Hospital which was the nucleus of the faculty of the present I.U. Medical School. This process of organization represented a lot of "politics." Dr. Link was one of the 16.

Instructor Leaves, Career Begins

The instructor in anatomy of the head and neck left Indianapolis rather abruptly, leaving Dr. Link to take over. This became an asset to him as his career in thyroid surgery unfolded. Early in his career the profound and abnormal physiologic effects of the thyroid gland on the body intrigued him. He necessarily had to have an accurate appraisal of these effects, especially on the cardiovascular system. Removal of the goiter had to be done when its toxic effects were sufficiently subdued. Failure to save the patient's life or to cure the disease by removal of the goiter persuaded him to look to the anesthetist, internist, and pathologist for all the help available. At that time there was nothing to offer the patient with hyperthyroidism except bed rest and sedatives, hoping for incomplete remission of the disease.

His attack on exophthalmic goiter was ligation of its blood supply and lobectomy in stages, often three to five operations. His first patient died after ligation of the superior thyroid artery, apparently of thyroid crisis. His second patient was Dr. Kimberlin's niece; ligation subdued her disease. His first excision of a goiter,

* Cardiologist in private practice in Indianapolis and a long-time friend of Dr. Link.

a bilateral subtotal excision, done three months after ligation of the superior thyroid arteries, was a complete success. About this time Dr. Charles Mayo had done 16 thyroidectomies with four deaths, a 25% mortality. After Dr. Link did ligations of the superior and inferior thyroid arteries through the same incision, all under local anesthesia, his patients improved remarkably. He was the first to ligate both arteries through the same incision.

The first internist to guide and encourage him was Dr. Kimberlin, clinical professor of medicine, Indiana University School of Medicine. The literature at that time offered very little. Dr. H. S. Plummer was one of the first to popularize the use of Lugol's solution in this country in 1922. About 50 years before, Lugol's had been used with great benefit in toxic goiter when it was given by mistake for tincture of digitalis. (Ashes of sponge and seaweed in the treatment of goiter in the 12th century is recorded).

Dr. Link went to Mayo's to visit Drs. Mayo and Plummer. The Swiss School with Dr. Kocher's great surgical ability held the dominant world influence. With the use of Lugol's solution and staged ligation procedures and lobectomy when necessary, Dr. Link's success in thyroid surgery progressed rapidly. After Dr. Kimberlin was accidentally killed in 1921, he teamed with Dr. Robert Moore, who was one of our outstanding cardiologists and teachers. If Dr. Moore were living he would be writing this article in appreciation of Dr. Link's contribution to internal medicine. These two men became close friends and had a long and valuable association in practice. Dr. Moore was consultant to Dr. Link in his most active years as a thyroid surgeon. In most of those years preparing a patient with toxic goiter for operation was much more difficult. Dr. Link was the first physician in private practice in Indiana to use tapazole in 1950.



DIRECT auscultation of a patient by Dr. Link.

For the internists who best know the problems of toxic goiter, Dr. Link has been much more than a surgical technician. He did become a great technician and has contributed to this aspect of thyroid surgery, as well as abdominal surgery. I think he also qualifies as an internist, as I shall further indicate. I would even recommend him to be an honorary F.A.C.P. His pioneer work and total contributions to the diagnosis and treatment of goiter would justify this honor. He has received an honorary LL.D. degree from Butler University and an honorary Sc.D. from Indiana University.

Direct Auscultation

Dr. Link did not carry a stethoscope, although it was introduced by Leannec in 1819. His pre-Leannecian method of direct auscultation of the heart and lungs is shown here in a recent photograph taken while examining a patient. This is not ludicrousness. This method of auscultation with the ear on the chest wall enables him to detect hypercontractility of the heart in thyrotoxicosis by delicate "palpation" in the same maneuver. He also recognized the heart sounds of rapid filling of the heart. Although most clinicians use a stethoscope on the exophthalmic goiter to detect the arterial and venous hum often present in this condition, Dr. Link found it of no help. Most older clinicians could detect valuable clues of disease from the character of the pulse. This art Dr. Link possesses.

Occasionally an intern or medical student wonders if such an obsolete method indicates an antiquated physician. Quite the contrary, no surgeon, and I emphasize surgeon, of my acquaintance acquiesced so well to the changing methods of diagnosis and the radioactive treatment of goiter. However, he stood firm against poor methods, such as external radiation (x-ray) of the thyroid, except in rare instances when it was used by others in preparation for operation. Roentgen therapy of hyperthyroidism was used at one hospital in Indianapolis until about 1953, long after it had been abandoned over the country. He still uses the term nodular goiter and believes it should be removed unless a type of chronic thyroiditis can be proven.

For the few young surgeons starting their private practice who have assisted him in operations to gain experience, Dr. Link has much pride, praise and gratitude. He emphasizes that they helped make him a better surgeon.

Dr. Link has the poise and charm to capture the confidence of the patient and family. His large consultation practice indicated the respect of his medical colleagues for him. He expected his patients who could, to pay a fair fee and they did. He has always astonished me in his astuteness as a bedside clinician. He taught

me more about goiter and its detection on physical examination than any other person. Feeling a restrosternal (substernal) goiter is difficult and often missed. Dr. Link believes the clinician should be able to feel the thyroid gland and determine by palpation if it is diseased. This rule avoids being fooled by psychoneurosis and other conditions simulating hyperthyroidism. On the other hand, he is uncanny in detecting mild hyperthyroidism. I must admit that today we rely too much on "thyroid tests" and minimize the value of proper history and examination of the patient. In the past we have all seen "treatment," including subtotal thyroidectomy, of an elevated basal metabolic rate (B.M.R.). The elevated B.M.R. often is a technical error, non-basal condition of the patient or some other disease causing hypermetabolism.

A "Man for All Seasons"

My pleasant association with him began when I started practice in Indianapolis in 1940. I have always been interested in disease of the thyroid and cardiology. After Dr. Moore's death my work with Dr. Link increased, not only in private practice but in utilizing his great experience and teaching ability for students, interns and residents at St. Vincent's Hospital. In 1955, a thyroid clinic was started by Dr. Link at St. Vincent's. His teaching in thyroid diseases centered around the outpatient clinic and interesting inpatients. His knowledge of fundamental physiology of the thyroid and its clinical application is good. His long experience often expressed as "teaching pearls" attracted many staff physicians to his clinic. After the number of outpatients decreased, due to the increased therapeutic use of radioactive iodine, a clinic has been irregularly scheduled for him. He enjoys teaching. He did his last subtotal thyroidectomy in 1967, at the age of 88. This patient would be an interesting case report, emphasizing Dr. Link's skill. There was a lipoma anterior to the goiter and each was removed separately.

One evening about twenty years ago, Dr. Link called me to join him in consultation in the case of a young mother dying in thyroid crisis. The young surgeon who had done a subtotal thyroidectomy that morning did not have medical consultation and had operated too soon. It was the first death in thyroid crisis I had seen in private practice. Dr. Link had not seen thyroid crisis in 20 years and neither of us has seen one since.

It is of concern to me that, with all our surgical training programs, we do not produce well-trained thyroid surgeons. The increased medical management of goiter and the small number of operations now done for this condition probably accounts for this deficit.

Dr. Link's ability in doing subtotal thyroidectomy, especially in severe exophthalmic goiter, was uncanny. To remove the proper amount of thyroid tissue to cure the disease without recurrence or myxedema is an art. He demonstrated that the inferior thyroid artery carries about ten times more blood than the superior thyroid artery. First, the superior thyroid artery is isolated and clamped. The inferior artery must be ligated within the gland; it is not clamped. Only by experience can the surgeon learn how much gland to remove; most of the posterior portion of the thyroid capsule is left. The parathyroids are supplied by the terminal branches of the inferior thyroid artery. Dr. Link did not see tetany in his patients. He has used catgut, cotton and silk, but prefers silk. The rule that "a parenchymatous organ will meet its physiologic demands for secretion by hypertrophy if the blood supply is adequate" is fulfilled—Dr. Link.

How well I recall the first patient with acute viral thyroiditis that I diagnosed. This was in 1950. In a few years Dr. Link had diagnosed a hundred cases. He planned to report them but never got it done. This wide experience with a "new" condition reflects the large number of patients seen by him in his office.

Although the medical preparation and observation of the thyrotoxic patient for subtotal thyroidectomy improved with the antithyroid drugs, Dr. Link's very strict rules in deciding when the patient was in an euthyroid condition, or was safe for operation, have never changed. These rules, evolved from his large surgical experience, attest to his great success as a thyroid surgeon. Only a few months ago I had Dr. Link see a patient of mine with thyrotoxicosis. He was under preparation for operation but had gained little weight. At Dr. Link's suggestion, I sent the patient home to wait until he gained about ten pounds. The man returned two months later for operation. He did well and was dismissed five days after subtotal thyroidectomy.

Active Mind; Long Life

Naturally, the most exciting medical experience in goiter for me has been the care of cardiacs with thyrotoxicosis before, during, and after thyroidectomy by Dr. Link. Not infrequently thyrotoxicosis appeared to be the only cause of congestive heart failure, particularly in nodular goiter. Dr. Link liked to say, "I leave the heart problem to you." He has had many patients in whom congestive failure did not recur after operation. This problem, i.e., is there pure thyrotoxic heart disease, dates back almost a century and a half and has not yet been answered. Dr. Link thinks, as I do, that it does not exist. However, most cardiologists say high output cardiac failure might occur with a normal heart.

In 1955, I had the pleasure of going to the American Goiter Association meeting in Oklahoma City with Dr. Link and again the next year to the meeting in Chicago. We went on the train. This gave me the opportunity to know more about this scholarly

man. He is the best read physician in non-medical science I have ever known. In the scientific meetings he had the same comment any older clinician would have—"This is research stuff without much clinical application." When there was a "clinical paper" he entered into the discussions, both surgical and non-surgical, with clarity and with favorable comment from the older members who knew him. His non-surgical knowledge of diseases of the thyroid is great.

I have been Dr. Link's physician a few times. His health has been good. He has lived an exemplary life without tobacco, alcohol, or over-indulgence in food. He has had adequate rest and exercise and above all he has worked hard in his profession. He is still practicing medicine at 91. He has saved hundreds of lives by his skill as a surgeon and his astuteness as a clinician. He has stood tall professionally. As president of our county medical society in 1942, he tried to initiate philosophies that would preserve the position and rights of physicians. These were considered radical but time has proven he was right. He has a curious mind. He studies. He enjoys life. He has been a good husband and father. He believes in God. He goes to church. I have always admired him.

Recently he said to me, "If one keeps his mind properly active, he can drag his body around for a long time." ◀

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From *The Journal* 50 Years Ago

While the majority of cases are reported to have had a "cold" or "influenza," preceding the attack of encephalitis a smaller number have been noted that were entirely well before the onset . . . . It is strongly suggestive that epidemic encephalitis is caused by either the germ and virus responsible for influenza, or by another micro-organism whose symbiotic existence is dependent on the prevalence of influenza in the community.

* * *

It seems logical to conclude [from many references] that beneficial results will be produced if the increased intracranial pressure be reduced, or if the toxin of the cerebrospinal fluid be diluted. One obvious solution to both problems is the frequent withdrawal of portions of the circulating cerebrospinal fluid . . . . It is becoming more and more evident that the benefits derived from intraspinous therapy in meningococcus meningitis, are in a large part due to lowering of the subarachnoid tension, and to dilution of the cerebrospinal fluid.

* * *

There are two practical methods by which tension in the subarachnoid space may be lowered. The principal and simpler method is by lumbar puncture. Inasmuch as there is no cause for adhesions or other obstructions to form and prevent free circulation of the cerebrospinal fluid, there is no apparent reason for choosing the intraventricular or cisterna magna routes. The more complicated and less frequently indicated method is the intravenous injection of hypertonic solutions of electrolytes. Salt solution and glucose solution are the electrolytes commonly employed . . . . R. V. Hoffman, M.D., South Bend, "Epidemic Encephalitis in Northern Indiana," *JISMA*, July, 1920.

Dr. Goethe Link--Fraternity Loyalty

ROBERT WM. HARGER, M.D.
Indianapolis*

GOETHE LINK began public school late, in the fourth grade, and finished Otwell Grade School in 1890 at age 11. He had been tutored at home by his mother, and that preparation was solid. He finished Petersburg High School in 1894, 2nd in his class, top man, *The Salutatorian.* (There was three in the class, the other two were girls.) Because Goethe was only age 15, his family got special permission for him to enter Wabash College as a freshman in the class of 1898. His studies were the typical pre-med classics and no snap for him.

He survived the celebrated student-faculty protest there in 1895. At Wabash, President Burroughs had introduced the strict discipline and high standards of his previous experience from Princeton and Amherst. He was a very cultured and serious educator, taught philosophy and biblical literature, in addition to administration duties. However, about two-thirds of both faculty and students withdrew because of what they felt was an overdose of minutiae. After the turn of the century a new administration was able to soften that image.

For his junior year, Goethe transferred to Indiana University. He was always the youngest and smallest man in class, so diplomacy and hard study went hand in hand. He enjoyed a wide acquaintance; and every friend became a lifelong treasure.

Bicycle racing was extremely popular as a county fair and weekend spectator sport. College men took their equipment by train to nearby communities to compete. It was an ideal sport for a small man with leg power, quick reflexes, and the discipline to practice. Young Goethe, at never more than 128 lbs., was ideal for this exciting part-time interest. He was able to take on the giants and leave them in the dust.

A classmate from Crawfordsville, Jack Banta, was the acknowledged expert bike racer of Wabash College. He taught many to race and Goethe was his best pupil. After winning his novice race at Danville, Illinois, young Link was approached by manufacturers from Chicago who asked him to endorse their product, the Rambler Bicycle. He did so, and with their bike won a handful of diamonds at events all across Indiana, Illinois and Kentucky. For amateurs the first prize was always a small $35.00 diamond. Those stones were small, square, yellow diamonds with poorly rounded edges, not worth much more than $35.00—even in today's market. Dr. Link traded all of his for a larger stone, which was also not perfect. That poor diamond trade led him to a long association with Dr. Frank B. Wade, a Shortridge High School chemistry professor, the mid-west's outstanding gemologist.

I.U. Upperclassman, Eugene Bishop Mumford (the late Indianapolis orthopedist) knew of Goethe's racing prowess and recognized him on the train when they came up to I.U. for the fall semester in 1896. "Bish" spiked Goethe for the Indiana Beta Chapter of Phi Kappa Psi Fraternity. Goethe's dad agreed to this as he had been a member of Phi Delta Theta at Hanover and "any good fraternity was fine with him."

A college fraternity of the nineties was not large. There was no pledge training, hell week, grade "accum" to make, upperclassmen's rooms to clean, or parking places to find. Each fall the new boys were quickly spiked (pledged) and badging (initiation) soon followed. Although members often roomed together, the chapter did not live and eat in the same building. Goethe roomed with another Phi Psi pre-med student on Kirkwood Ave., west of the railroad. There was a Mexican War veteran next door who had many tales to tell of the good old days.

In its first years at I.U., the chapter met and held formal ceremonies at the Phi Psi Hall over a drugstore on the northwest corner of Railroad and Kirkwood Streets, one block west of College Ave., in downtown Bloomington (along the levee). Their first furniture cost $21.00, but by 1892 the hall insurance was raised to $500.00 for all they had acquired in 22 years. An electric meter was installed and 10 incandescent lamps were lighted for the first time at a Grand Social on Dec. 11 and 12, 1891. Electrical repairs were voted the next year, but an extra lamp was *not* placed in the stairway. In June, 1893, the electric lights were removed, and the chapter resumed use of coal oil lamps with a new five gallon storage can.

In 1894 the Phi Psi Hall was moved to the Southwest corner of Court House Square, again on the second floor. The central location made it ideal for social events as well as formal meetings. Use of the hall was often loaned to alumni, high school groups, other fraternities, sororities, university groups and even to *Skulls*, an extracurricular campus group with variable popularity and inconstant esteem.

At times they hired out janitor

* An ophthalmologist, Dr. Harger is a fraternity brother of Dr. Link's and a personal friend of many years.

work, but gradually adopted a rotation of that chore among the members. Heat was provided by a wood stove. Several committees were appointed to acquire a suitable door mat, but none could be found in any of the Bloomington stores. Meetings were usually held Saturday night.

Fraternity life was not cheap, many of the "barbs" (non-joiners) could not afford it. A typical share of costs for each member per semester:

Hall rent and repairs	$6.00
Dues	$8.00
Social	$15.00
Total	$29.00

No chapter treasury was managed without alumni supervision and rarely had more than a $50.00 bank balance. In 1879 a short term note was signed for the frat to borrow $30.00 at eight percent interest. Recent grads even then sometimes needed to pay back-dues after leaving school. Undergrads (including Link) occasionally pawned school books to get money for train fare home between semesters.

Much of the hall furniture, rugs and furnishings were donated by families from all over the state. And until 1900 the alumni agreed 100% that the chapter could not afford a fraternity house, just to keep up with the others!

In 1896 there were 34 active members of the chapter, including 15 alumni, 10 attending (upperclassmen), and nine new initiates: (two freshmen, two sophomores, five juniors, seven seniors and two special students; including eight legacies—two nephews, five brothers and one cousin). Total university enrollment was nearly 1000, (619 male). There were 363 members on the grand roll of I.U.'s Phi Psi Chapter (now after 101 years there are over 1600). It was then and still is the longest chapter roll in the entire Phi Kappa Psi National Fraternity.



DR. LINK is shown with his bicycle in this picture taken around 1894 or 1895.

The other I.U. Greeks of 1896 listed attending members as:

Phi Delta Theta	27
Sigma Chi	20
Sigma Nu	18
Beta Theta Pi	17
Delta Tau Delta	17
Kappa Alpha Theta	33
Kappa Kappa Gamma	25
Pi Beta Phi	16
Alpha Zeta	10
Phi Kappa Delta	10

The chapter correspondent for 1896-7 reported great things for the university. Under Judge Banta the law department had expanded widely. There were new undergraduate courses in fine arts, drawing, and history of architecture. A new gym was completed, standing just east of Owen Hall. Half of it was an auditorium seating 1500 people. The Old Chapel, Mitchell Hall, was refitted as a ladies gym. The basement of Owen Hall and the library had both been renovated.

Football had undergone a great revival that fall under a three year veteran halfback from Harvard who had come in as the new gymnasium director and football coach. The student body was never so inspired with confidence in their team and coach, for they won games against Butler, Cincinnati, Wabash, and DePauw. That placed them next to Purdue in state football rank.

Goethe did not have time for campus athletics. He continued bicycle racing and worked out by running long distances with "Bottle Nose" Owen of New Harmony. Brother Owen was also an active bike racer. Dr. Link credits his five years of training for competitive bicycle racing as having played a strong part in developing stamina that carried him through hypoxia of the 1909 Balloon Race and the many long days in surgery after he went into the practice of medicine.

Typical of all fraternities, the activities of its members sounds like *Who's Who.* The 1896 Phi Psi president was captain of the football team (a mean right tackle—even with an injured knee). He was also second tenor in the glee club, but top honor of the year was his winning the primary oratorical contest with a presentation of *"The Awful Situation of the Armenian People."* There was strong competition among both the "Barbs and the Greeks" to have leadership positions in football, baseball, glee club, student board, debating team, oratorical association, lecture association, and university band. The fraternities and sororities caucused for editorial assignments on

both *The Student* and *The Arbutus*. The campus newspaper had been published for several years, but the yearbook was first printed as the *I.U. Annual* in 1894. The chapter boasted two alumni on the I.U. Board of Trustees who had won political elections that fall, Appellate Judge Wood Robinson of Princeton and Congressman Charles Henry of Anderson.

Goethe S. Link was initiated on September 29, 1896, with *Arthur Stout* of Paoli. The slogan of new members was "We have met the goat and we are his! High, High, High—Phi Kappa Psi—Live Ever, Die Never—Phi Kappa Psi!" Chapter minutes note that Goethe gave a fine talk after the two neophytes were "badged" by Mr. Lawrence Van Buskirk. "Mr. Van," the mayor, postmaster, and leading banker in Bloomington, was for more than 20 years Indiana Beta's finest chapter advisor, strict in standards, aggressive in goals, loyal in effort, sensible with money, and always sympathetic to youth. For one term Brother Buskirk was presiding officer of the Phi Kappa Psi National Convention, the Grand Arch Council. He was strong for extension of chapters then being considered at Nebraska, Stanford, Wisconsin, Cincinnati, Missouri, Vanderbilt, Purdue and Boston Tech.

On October 10, 1896, Brother Link was appointed to the *Committee for Literary Work*. Their mission was to divide the membership into groups for program assignments. At various intervals a personal journal was read called the *Tattler*. Chapter meetings were often a proving ground for campus orators. They took part in debates, original talks, readings, declamations and orations. The issues were sometimes light, sometimes serious, and each member's performance was judged by his peers. If he were absent or unprepared, his program was held over for a later meeting. The topics were timely:

Value of Chemistry
Modern Journalism
The Negro Question
The Nicaragua Canal
Review on Telepathy
News of the Week
Fraternity Studentship (grades)
Position of Athletics in College
What Are We Here For?
Sketch of P. B. Shelley
Resolved That Specialization in College is Necessary
Hypnotism
College Library and How To Use It
Education Value of World's Fair
Lowell as Educator
Resolved That the World's Fair Be Closed on Sundays
How To Make Chapter Meetings Attractive
Are Large Chapters Advisable?
Which Is the Butt End of the Goat?

On October 17, 1896 the entire meeting was given over to *formation of a dancing class*. There is no note of Goethe's reflexes in ballroom athletics, but he recalls social events with both the Kappas and the Thetas. At one point the music committee was instructed to get Sig Maroney for the next dance. If that was impossible, the committee was instructed to use its own judgment.

School days were not easy. Dr. Link was an average student; he had to work hard to master the subjects. His fraternity association was a great benefit in this regard. The French professor was an alumnus of the chapter so he sent word via the chapter president that Goethe should work harder. That stimulus was just the push needed to acquire a high proficiency in French. He became an avid reader of French and this helped greatly in later years both in reading medical literature and in his use of Spanish.



AN early picture of Dr. Link (around 1904) when he wore a mustache for two to three months to look older. His Phi Kappa Psi pin is on his lapel.

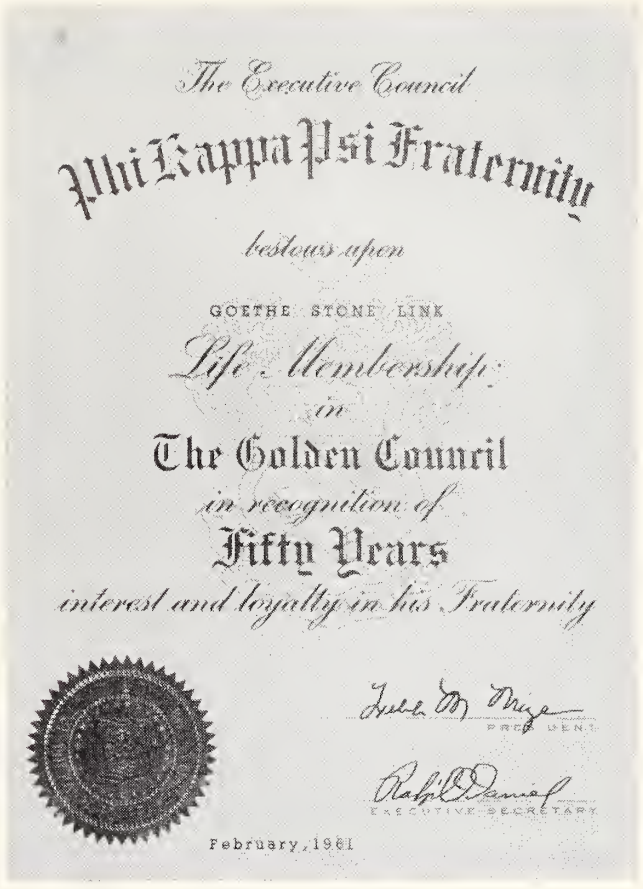
He also discovered that strong bond of common grief as well as personal sorrow that every fraternity feels when tragedy strikes. The entire chapter was saddened when one of its members was killed on Christmas Day, 1899. After escorting his fiancee aboard the southbound Monon at Roachdale, the victim fell and was dragged while trying to board the northbound train which was already moving out of the depot.

Dr. Link says, "Fraternities are exemplary organizations of all time. I urge them to remain strong." He prizes his membership highly and found great pleasure in having both of his sons initiated. Elder son, William, has degrees from both DePauw and Harvard, and Goethe, Jr., has both of his degrees from Indiana University.

In 1902 while on the medical school faculty, Professor Link became a member of the newly installed Phi Rho Sigma Medical Fraternity. He wore the Phi Psi Badge on the top of his lapel and Phi Rho pin just beneath it. Countless times he met members of both organizations just because they recognized his insignia. Once a leading surgery professor in the East was startled to find that they belonged to both fraternities together. They were "double brothers," and ever after no favor in the study of medicine was too great when Dr. Link visited that hospital. The fraternity was never used as a ladder to social or professional advancement, but so

often it happened without his seeking any gain.

Fraternity rush has been his chief contribution in recent years. He never misses the Annual Career Conference —"What's Your Line?" that the chapter convenes each summer for fathers and sons. He has that priceless ability to give a gentle push or pull to someone else who has a mutual interest. When words of loyalty are spontaneous, Dr. Link leads all the rest. He sells his fraternity by promoting the university (where bicycle racing is more popular than ever). The chapter has also met at Link Observatory and at his home on Tanager Hill.


The Executive Council
Phi Kappa Psi Fraternity
bestows upon
GOETHE STONE LINK
Life Membership
in
The Golden Council
in recognition of
Fifty Years
interest and loyalty in his Fraternity
PRESIDENT
EXECUTIVE SECRETARY
February, 1961

PHI KAPPA PSI bestowed a life membership certificate on Dr. Link in recognition of his 50 years of membership in the fraternity.

He has not been a joiner outside the medical and scientific fields. He belongs to the staff societies of all Indianapolis hospitals; Fellow, International College of Surgeons, Indiana Academy of Science; American Goiter Association; Marion County Medical Society; Indiana State Medical Association; American Medical Association; President Emeritus, Indiana Astronomical Association; Audubon Society; Ornithology Society; Herpetologist League; Nature Study Club of Indiana; and the Methodist Church of Mooresville. For him the greatest honor ever achieved was to be president of the Marion County Medical Society in 1942.

AS DR. LINK HAS HONORED HIMSELF, HE HAS BROUGHT ESTEEM, PRIDE AND STRENGTH TO ALL OF THESE ORGANIZATIONS. ◄

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Dr. Goethe Link--Association with a G.P.

JOHN COURTNEY, M.D.
*Indianapolis**

LONG after Dr. Link had attained a considerable degree of medical renown and a very comfortable level of income, he continued to share a distinctly unfashionable office in the old K. of P. Building with his long-time medical friend, Dr. Thomas E. Courtney.

These two, diametrically opposite in many personal characteristics, were linked by a common devotion to the highest standards of medical practice—and an uncommon respect for each others' talents and character. Dr. Link had the successful surgeon's characteristic self-confidence, joined with scrupulous care and an abundance of native talent. Dr. Link tended to be direct and almost imperious, but he appreciated and admired the warm, gentle, and compassionate manner of his older office partner, Dr. Courtney, whose general practice was necessarily psychosomatic long before the term was coined.

The two enjoyed a rare relationship for more than three decades. They shared intellectual enthusiasms outside the bounds of medicine. Abraham Lincoln, Aaron Burr, and general American history were among their particular shared interests. In younger days they had enjoyed exploring together the Hoosier countryside in the highly unreliable motor vehicles of those pioneer days. Both enjoyed contact with nature and, although scientifically oriented, both had a streak of adventure which sometimes led them into somewhat unprofessional postures.

Although their social lives were on completely different tracks, they maintained, until Dr. Courtney's death, a personal relationship which was a rare blessing to both. They gave each other an example of professional devotion and competence, of personal integrity and of mutual respect and regard which must have been one of the most satisfying aspects of Dr. Link's highly successful career. ◄

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* Radiologist, St. Vincent's Hospital and Northwest Medical Center, Indianapolis.

Dr. Goethe Link--Family History

HELEN KEGERREIS LINK
Brooklyn, Indiana

THE paternal ancestor of the Link family was Joseph Mary Lingg who came to America from Switzerland. He had studied for the priesthood, but before taking his final vows decided to marry and left the church. He and his wife settled in Pennsylvania where he was a cooper by trade. His name was changed to Link due to phonetic spelling. The family consisted of four sons, two of whom migrated to Perry County, Indiana. One of these, Elijah Link, married Susan Huff and to this union were born six children. The eldest was Jesse who became a lawyer and practiced at Boonville, Indiana. He married Nancy Hall and to this union were born eight children, among them William Hall Link, the father of Goethe Link.

William Hall Link became a school teacher and obtained a Life State Teachers License at the age of 17 by passing an examination. He taught school at Selvin where he married and where Goethe was born. Later he became Superintendent of Schools at Petersburg, Indiana. He attended Hanover College as had his father before him. Due to a prank played upon the college president by some of his friends, his diploma was withheld. Although William did not take part in the prank, he knew who did participate, but would not reveal their names; he finally was cleared when those who were guilty confessed and he received an A.M. degree. He married Phebe Stone and from this union were born four children, two of whom died in infancy. Goethe was born when William, a student of literature, was reading Goethe's *Faust*, thus that name was given to him. The other child was a daughter, Mona Link Agnew.

When Goethe was born, William was so disgusted with the technic of the elderly doctor who delivered his son that he thought he could do a better job and decided to study medicine. He received his M.D. degree from Ohio Medical College where he had studied aseptic surgery under Dr. Ransahoff, a Fellow of the Royal College of Surgeons, England. He located at Otwell, Indiana where he practiced medicine and surgery as he was the only doctor in that area with surgical training. He later moved to Petersburg after taking a course in surgery with Joseph Price of Philadelphia. When he returned from Philadelphia he did the first aseptic abdominal surgery in that part of Indiana.

Young Goethe was brought up in his father's office. He knew all the names of the drugs his father dispensed. He went with his father when he made sick calls, and it was his duty to clean the surgical instruments following an operation which usually was performed on the kitchen table in those days.

Schooling, Internship

Goethe was small of stature, and although interested in athletics was not built for rugged sports so took up bicycle racing. He competed at races in Indiana and Illinois at state fairs and won many times. He spent several summers on the farm of his grandfather Stone where he learned to love nature. At the age of 15 he was graduated from Petersburg High School. He attended Wabash College two years and then transferred to Indiana University. He spent a year working in a Petersburg drugstore and became a registered pharmacist in 1901. In 1902 he received his M.D. degree from the Central College of Physicians and Surgeons in Indianapolis.

The City Hospital in Indianapolis was the largest in Indiana at that time



A grade school graduation photo of Dr. Link, the smallest boy in the class (1890).



DR. LINK and his graduating class from Petersburg High School.



TWO "sports" pose for a photo, complete with spats and bowler derbys, in 1894. Dr. Link is on the left.

and it was the dream of all young doctors to further their education by taking an internship at City Hospital. The recipients of the internships were decided by an extensive examination, both written and clinical, which lasted six days. Dr. Goethe won first place and served his internship in 1902-03.

Dr. Link helped to organize Indiana University School of Medicine and was made Director of the Anatomical Laboratory; he also became Associate Professor of Genitourinary Surgery at the Medical School and later Assistant Professor of Gynecology, a position he held until 1922.

In addition to being a member of the surgical staffs of City, Methodist, St. Vincent's and St. Francis hospitals, he also served as Secretary of the United States Pension Board of Examiners. He was a member of the Board of Examiners during World War I. Since 1903 he has been a member of the Indiana State and American Medical Associations. Other positions included being a member of the Indianapolis Board of Health 1922-27, President of the Indianapolis Medical Society 1941-2, member of the American Association for the Study of Goiter, and a Fellow of the International College of Surgeons.

As Dr. Link's surgical practice grew he began to specialize in thyroid surgery for which he was well qualified as he had taught the anatomy of the head and neck in medical school. He had studied in Boston, Philadelphia, and at the Mayo and Crile Clinics.

A Learned Man

Dr. Link has always been interested in any study which gave him knowledge. One of his greatest pleasures in life has been learning. He became interested in astronomy, gemology, photography, aeronautics, herpetology, ornithology and all aspects of nature. He became a member of the American Herpetologist League, the American Astronomical Society and a Fellow of the Indiana Academy of Science. Butler University conferred an Honorary LL.D. degree on Dr. Link in 1941, and he received an Honorary Sc.D. degree from Indiana University in 1958.

As a family man Dr. Link gave freely of love, tenderness and knowledge to his wife and children. In 1911 he married Miss Clara Leonard who was a graduate nurse. To this union were born Lucy Link Woodard and William Hall Link. The family was split after several years by the death of his wife. For seven years he devoted his life to his children and his work. In 1937 he remarried, again a member of the nursing profession and his suture nurse, Miss Helen Kegerreis. To this union was born a second son, Goethe Link, Jr.

As Dr. Link's practice became large and demanding he began to spend a few weeks each winter relaxing and enjoying his hobbies. For 25 years he wintered in Arizona and Texas where he enjoyed playing golf. To break the monotony of "all play" he enrolled in Phoenix Junior College and took a course in astronomy and also one in anthropology. At Laredo, Texas Junior College he studied Spanish and became proficient in a third foreign language. He had studied German and French during his college days and still reads medical literature in both languages.

During Arizona vacations he spent some time at Flagstaff where he furthered his interest in astronomy. He enjoyed the companionship of Dr.

FAMILY TREE OF GOETHE LINK, M.D., LL.D., Sc.D.

JOSEPH MARY LINGG
Born 1754? — Switzerland — migrated to Penn. 1775?
Married — unknown

Nicholas, Joseph, ELIJAH, Conrad
m. SUSAN HUFF 1827

Mary, John, Joseph, JESSE, Samuel, Annie
m. NANCY HALL 1846

Harriet, Emma, Katherine, WILLIAM HALL, Annie, Jesse, Jr., Alia, John
m. PHEBE STONE 1877
William Jr., GOETHE, Mona, Carrol
b. 1879

m. CLARA LEONARD 1911 (deceased 1930)
Lucy Jane, William Hall

m. HELEN KEGERREIS 1937
Goethe, Jr.

E. C. Slipher and his brother V. M. Slipher of Lowell Observatory, also that of Dr. Clyde Tombaugh who discovered the planet Pluto. His interest in astronomy became so intense that in 1937 he set up the Goethe and Helen Link Foundation for Scientific Research and built the Goethe Link Observatory near Brooklyn, Indiana which was later given to Indiana University. As a result of his interest and philanthropy in the field of astronomy, an asteroid now bears his name.

"Retirement" in Name Only

As the years passed and age necessitated partial retirement, more time has been spent at his country home which he named "Tanager Hill." It is located adjacent to the observatory, and it is here that the scarlet and summer tanagers also spend their summers. The fields abound with daffodils in spring, and occasionally a stranger stops to inquire about the observatory. Dr. Link, dressed in his old work clothes, is often asked whether he is the caretaker. At this retreat there is never a dull moment; the birds must be fed, a dead tree limb needs to be removed, a muskrat has made her home in the pond threatening the dam. In summer a colony of hummingbirds requires constant attention and behavorial study is made. In winter there are books on the shelves which must be read as they were placed there during the "busy years" awaiting this retirement.

During those busy years at the operating table, Dr. Link got up each morning at dawn and twice a week played 18 holes of golf with one of his best friends, Dr. Herbert McGinnis, who also enjoyed the game. His enthusiasm for the game has never waned; he frequently watches the pros play on TV and groans when his favorite player misses a putt. During his golf playing days he made a hole in one twice and participated in *The Indianapolis Star*-sponsored tournament for lucky players. In retirement he still arises early and on Sunday attends church services at the Mooresville United Methodist Church.

A surgeon who performed the first total gastrectomy in Indiana and the first caudal drainage of the pancreas in the world, as well as over 20,000 thyroid operations in a lifetime and enjoyed every moment of it, will never be idle. He enjoys holding thyroid clinics and consultations. There are not enough hours in the day to do all the things he has planned. When asking him what has been his greatest enjoyment in life, he will reply, "Helping the sick to recover their health." ◄

Dr. Goethe Link--Political Personality

HOMER E. CAPEHART
*Indianapolis**

GOETHE LINK was born to be a great success. He would have been successful in any endeavor he might have chosen. He chose medicine and surgery—possibly because his father was a doctor.

Born on a farm near Dale, Indiana, in the year 1879. Lived in the little town of Otwell in Pike County, Indiana, where he attended grade school and his father was a doctor.

I was born in Algiers, a little hamlet near Otwell, in 1897.

Dr. Goethe Link and his father remembered all my ancestors who lived near Otwell and Algiers in Pike County and the hamlet of Ireland in Dubois County.

He particularly remembers my grandfather, William Kelso, because he was a giant of a man—7 feet tall, weighing 290 pounds—no fat. He was widely known because of his strength and his Republican politics.

Dr. Link was a Republican from his boyhood days. One of the reasons was that Pike County had a lot of Union soldiers who fought in the Civil War. They were solid and rabid Republicans and Dr. Link told me they had a lot of influence upon him. Yet he stated, "I just like the philosophy of the Republican Party. I started out as a Republican and I still am," he said rather proudly.

At this point in my visit with Dr. Link in his beautiful home near Mooresville in Morgan County, he enthusiastically made the statement that everyone should belong to a political party—*and support it.* He also said that every doctor should take an active part in politics. He claims politics in his early days of practice helped him to become well established.

Back in those days he called upon his patients and made trips to the hospital (the old City Hospital in Indianapolis, now General Hospital) in a horse and buggy.

On Election Day he hauled people to the polls in his buggy.

He was a great believer in helping his friends whom he wished elected.

While I have known of Dr. Link and visited with him on a few occasions over the past 45 years, I had occasion to visit with him for several hours recently. That is why I say he would have been successful in any line of work or profession.

In talking with him about his life and experiences, particularly as a young man, he would have fit right in with the young liberals and doers of today.

You know about his winning the Indianapolis Speedway Balloon Race in 1909. He was active as a young balloonist, bicycle racer and, in fact, all activities. Lots of energy. Outspoken. Hard worker. Wanted to succeed. Loved people. A man on the move. Enthusiastic about surgery and medicine. Great ability to concentrate.

Had there been astronauts when he was a young man, he would have been one or at least tried.

What I am trying to say is he believed in new things. (Sort of a conservative revolutionist).

Success, energy, enthusiasm and a love of life stand out all over him today—at a young 91 years of age. ◀

7251 N. Pennsylvania St.
Indianapolis 46240

* Long-time Indiana Republican, Mr. Capehart was U.S. Senator from 1945 to 1963.



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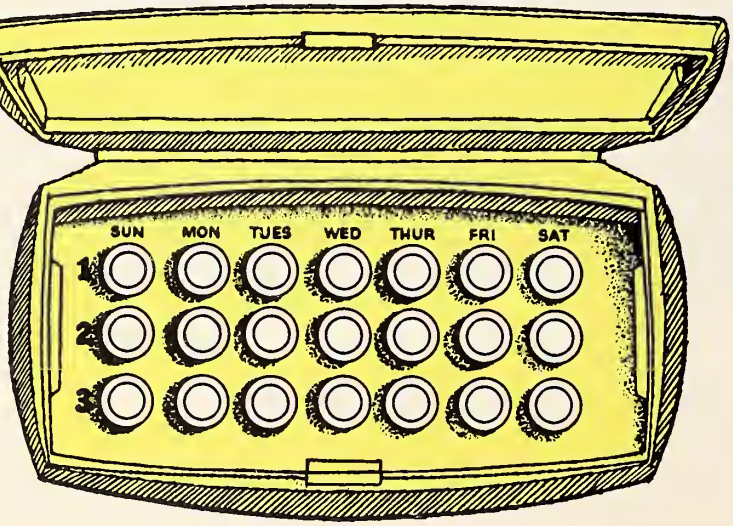
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Actions—Demulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Demulen depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Demulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

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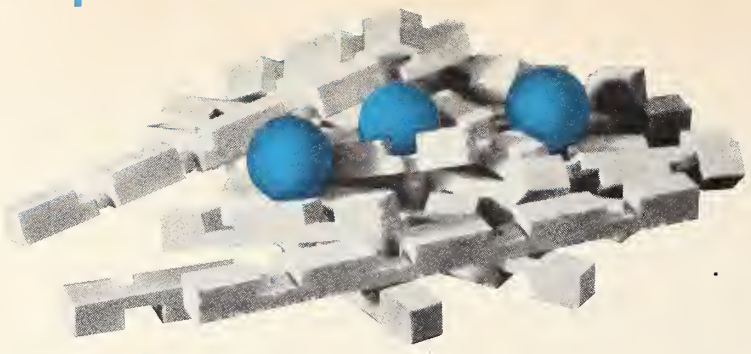
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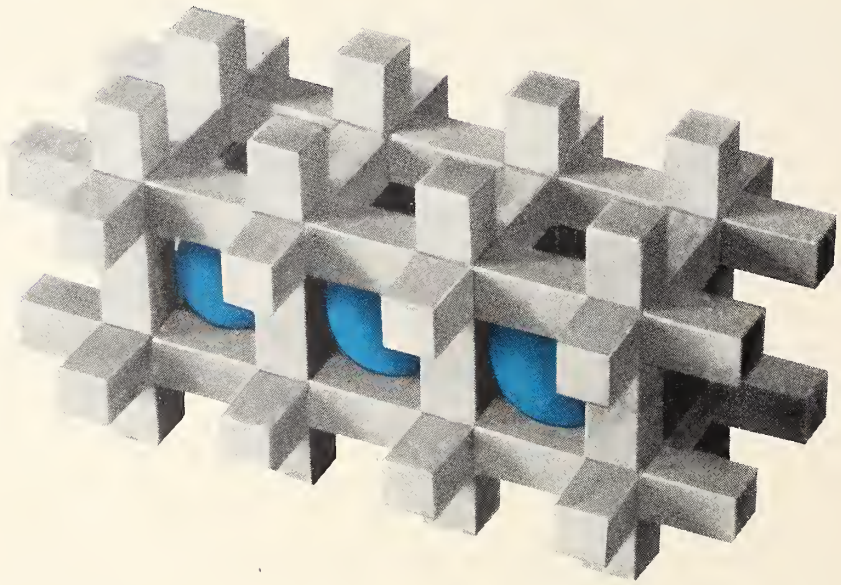
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Contraindications: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

Warnings: Do not exceed recommended dosages.

Precautions: Administer with caution to persons with known idiosyncrasy to atropine and cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

Adverse Reactions: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occurs, decrease dosage. If rapid pulse, dizziness or blurring of vision occurs, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

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References: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961: (2) Renner, M.J., et al: Hosp. Topics 39:71-73, 1961: (3) Haas, Jr., J., and Kay L.L.: Southwest. Med. 42:30-32, 1961 (4) Marshall, W.: Clin. Med. 7:499-502, 1960: (5) Strauss, B.: Clin. Med. 4:307-310, 1957.

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Guest Editorials

Guaranteed Income: A Step into Socialistic Chasm

SUPPOSE that some charitable fellow you knew began providing regular allowances to seven needy persons in your community.

And suppose that, it spite of good intentions all around, the results were discouraging. Because of the way the people were being helped, they lapsed deeper and deeper into dependency, lost self respect, grew unhappier, less motivated and more burdensome to their charitable friend.

So finally he says: "This can't go on. I must try something different. And in doing so, I will add 13 more persons to the list of those I am going to help."

How much sense does that make?

Shouldn't he first straighten out the original seven, before he involves 13 more?

Multiply the figures by a million and the questions will apply to the Nixon Administration's Family Assistance Plan which has been passed by the House and awaits consideration by the Senate.

There are almost seven million persons now on the family welfare rolls. The program is a mess. It breeds irresponsibility. It wastes tax money. Many of the mothers, who head 80% of the welfare families, could be made self-supporting but they are not being properly sought out and induced to take job training. So the families drift from one generation to the next, looking upon welfare as a way of life.

Now the Administration has set out to reform the system and its chief proposal is to take onto welfare 13 million more persons, all of them in families headed by fathers who work full time but who do not earn as much money as the Administration thinks their families should have.

It's the kind of a "solution" one would expect from social planners who are trying to conceal their poor aim by building themselves a much bigger target.

The new plan has some good features. But when it's all added up, it is a federally guaranteed annual income for all families with children.

The guaranteed annual income would be a step off the brink into a deep socialistic chasm. The National Chamber opposes it. If you do, too, then tell your senators and congressman about it.—**Arch N. Booth, Executive Vice President, Chamber of Commerce of the United States, Washington, D. C.**

Leadership in Waste Disposal

IT used to be the packing industry's boast that it made use of every part of the pig but its squeal. Of course, that's the best way of dealing with industrial pollutants—make use of them, so that there are no pollutants and no problem of their subsequent disposal.

That is why it is pleasing to learn that the new Clinton, Ind., plant of Eli Lilly & Co., which will begin operations this coming July, embodies this most modern of principles. Burton E. Beck, president of the company, has announced that one-fourth to one-fifth of the cost of the $40,000,000 plant represents waste disposal equipment. But by means of this expenditure, 90% of the normal production wastes of this pharmaceutical and agricultural chemical installation will be converted into steam power, an animal high-protein feed additive, and such harmless gases as carbon dioxide. The rest will be ashes.

Our hopes for the future of this world rest on successful application of such methods of utilization of waste—so that there is no waste—and the technique will ultimately have to be extended from the area of production to the area of final consumption.

We extend heartiest congratula-

tions to Eli Lilly & Co. To every other manufacturer we would say, Go thou and do likewise!—*Medical Tribune and Medical News*, May 4, 1970.

Editorial Notes . . .

Training deaf people to speak is difficult because they cannot determine when they have produced the desired sound. Precision Acoustics Corporation makes an electronic device which converts the sound of the human voice into a series of squares of light on a screen. The instructor speaks and freezes the pattern on the screen. Also transparent master sheets may be placed in front of the recording screen so that the student may practice his speech until the patterns coincide.

Increasing numbers of disabled veterans are studying in colleges and pursuing on-the-job training under the sponsorship of the Veterans Administration. Trainees in both programs number 14,800, 4,100 more than last year. On-the-job training increased by 48%. This is an especially fine type of VA training since there is a job waiting for each trainee.

Rochester, New York, will determine whether public schools can be used more effectively as a base for meeting health needs of children under a grant from the Commonwealth Fund. The University of Rochester School of Medicine and Dentistry, in cooperation with the Rochester public schools, will conduct a pilot program for two years to include (1) training teachers in child growth and development, drug abuse and narcotics addiction, (2) evaluation by pediatricians of children with learning or behavioral difficulties, (3) medical treatment and follow-up by pediatricians, and (4) referral of children with complex problems to the university clinics.

Hospital expense per patient-day in 1969 was $68.41—$9.15 higher than in 1968. Average length of stay was 8.1 days—the same as for 1968. The cost increase was by inflation of cost of supplies and equipment—up by 26%. Personnel costs were up by 11.9%. It is to be expected that hospital expenses will continue upward by about 15% annually, due principally to hospital wage scales catching up with industrial wages.

The idiotic charge that lack of interstate reciprocity in medical licensure is responsible for the uneven distribution of physicians is neatly squelched by the AMA report that the several states which have almost unlimited reciprocity constitute a group of states in which the distribution of physicians varies from 1:562 to 1:1326. On the other hand states which have no reciprocity arrangements have ratios of 1:761 and 1:842.

Exercise is a major factor in sensible weight reduction says the Health Insurance Institute. The supposition that physical exercise does not burn up many calories, increases the appetite and increases intake is a fallacy. An excess of 96 calories per day will produce a weight gain of 50 pounds in five years. A brisk 25 minute walk per day will cancel the effect. Sitting still burns 100 calories per hour, driving an auto 120 calories. On the other hand tennis uses 4200 calories hourly and handball requires 600. All Americans need more exercise. They are being "elevatored" and "televisioned" to death.

Indiana is one of five states in which selected schools will test a comprehensive curriculum guide for teaching about drugs in kindergarten through high school. The guide is being developed by the American School Health Association and the Pharmaceutical Manufacturers Association and will be published about August 1.

Two viewpoints are possible in the diabetes screening and detection program. People who are overweight or over 40 years of age, or who have blood relatives who are diabetic, or who have given birth to babies weighing nine pounds or more are more apt to have diabetes. If only this high risk group is invited to the screening clinic a higher proportion of unknown diabetics will be discovered than if the general public is invited without specification. This produces a high score for the screening team, but at the same time tends to confer a false sense of security to people outside the high risk group, and misses some unknown diabetics, because not all diabetics have the telltale characteristics.

A gradruple amputee with four artificial extremities has received the designation "The Outstanding Handicapped Federal Employee of the Year." Robert L. Smith, 39, commutes daily from his home in Hyattsville, Md. to Washington, D. C. and performs a highly technical job as a computer programmer for the Veterans Administration. He lost his limbs as a result of wounds received in the Korean conflict. In addition to his normal workday, he serves many hours as a hospital volunteer encouraging other amputees.

The Atomic Energy Commission is aiding in the research to determine why fish in the Great Lakes are dying. The Argonne National Laboratory analyzes the metallic content of fish by reducing the tissue to an ash and subjecting it to a neutron source. Metals, such as copper, zinc, mercury and arsenic are rendered radioactive and can be quantitatively measured by delicate instruments. Fish from different locations and different depths will ultimately reveal the extent and nature of Great Lakes pollution by industrial wastes and agricultural fungicides and pesticides.

Lounge Talk

LLOYD L. HILL, M.D.
Peru

THE Chief of Staff-Trustee-Administrator Conference held Monday, May 18th, was a qualified success. If pursued with fervent internal direction, this joint venture of ISMA and IHA could provide an effective means to maintain the medical arts on a more rational course. Despite the fact that the majority of medicine is practiced outside of the hospital, the latter is a vital necessity to health care. Hospital administration and medical staffs, like the brothers they are, have long displayed rather typical sibling rivalry. The physician, being the older of the two, jealously guards his seniority in the field of medicine.

Hospital administration, on the other hand, has been given burdensome responsibilities for the care of hospitalized patients. These have created peculiar problems for it which medical staffs would rather ignore. While it is natural that the relationship of siblings during adolescence is one of competitive jealousy, they do share the strongest of all ties—family pride. With maturity, most siblings relate to each other affectionately in a spirit of family loyalty. It was most heartening to witness the cooperative spirit prevailing at this conference. This does not mean that all was sweetness and honey, but at least the willingness to calmly exchange views and obtain different perspectives did predominate.

My judgment that the conference was a qualified success is based upon whence the direction comes. Medical care is being insidiously controlled more and more by crackpots, pseudo-intellectuals and demagogues who have only the barest of superficial knowledge of the practice of medicine. The general tenor of the audience was one of common frustration with the overabundant static pervading the health field today. Through conferences such as this, we at least have an opportunity to rationally discuss our mutual and related problems, minimizing much of the noise erupting from the mouths of quasi-authoritarian lawyers, politicians, insurance representatives and union czars.

As President Steen would say—we no longer can afford the luxury of ignoring the dual responsibility shared by medical staffs and hospital administration. No one can deny that we are bonified partners in hospital care and are mutually interdependent. Certain transitions brought about through the continuing evolution in the practice of medicine do mandate definite changes in hospital care which require the cooperative efforts of both members of the hospital team. The technological innovations of today, while sensational, do apply to only a very small segment of our population. These nevertheless are welcome additions to our armamentarium which calls for well-coordinated planning by members of the health professions in order to provide them at a minimum of cost and a maximum of efficiency.

Medical staffs must provide the leadership and incentive to members of subordinate and ancillary medical fields through continuing educational programs if we are to expect efficient and skilled patient care commensurate with the modern modalities available to all hospitals—metropolitan as well as small community. The above problems are being met and solved by hospital and medical personnel; they are in no way responsible for the precarious state of today's hospital. Ironically, the vociferates who so irresponsibly acclaim the ineptitude of the medical profession in America are the very ones who are creating the most significant dilemma in the health field today.

Mr. Paul Young, an affiliate of Blue Cross of southeast Ohio, was a featured speaker who audaciously accused the medical profession of unnecessarily hospitalizing patients. An apt analogy to this charge would be that of a gunman mortally wounding his victim in broad daylight on the corner of Main and Broadway and then accusing the policeman directing traffic of committing the crime.

The "Fickle Finger of Fate Award," however, must go to Mr. Steve Enich. This ex-St. Louis Cardinal football player and lawyer from Wisconsin stood like a sphinx before this conference, repeating absurdity after absurdity inferring rampant malfeasance within the medical profession. His pomposity was exceeded only by his lack of understanding of the totality of medical practice. His prolonged, tiresome, albeit well read oration had his audience squirming and shaking their watches as he raved on and on, enumerating what he considered to be gross deficiencies in the medical profession, hospital administrators and the lowly hospital trustees. He surely must have written the gospel for the "Peter Principle." In spite of his flamboyance and physical impressiveness, this refugee from many battles on a football field lacks sufficient comprehension of the medical arts to qualify him as an authoritarian critic of the health professions. We should be granted equal time at the podium of one of his legal convocations to mention a few of the improprieties of his own profession. However, I doubt if the Mafia would allow it.

The above speakers notwithstanding, we did spend an entire day establishing a more effective dialogue between the truly allied medical fields of medical staffs and hospital administration. Through such cooperative efforts, we have a firm basis from which to regain control of the health profession and expose the fraudulent practices of a few "health crusaders" who are totally incompetent and untrained. We must seek our direction from within the medical professions themselves. Such conferences can

crystallize the means to achieve our common goals most expeditiously.

The inundation of slander upon the medical profession seems to be coming from all around us. Generally the perpetrators of this campaign are poorly or not at all qualified to make judgments of any value to the health care of our nation. Leadership in the health field must be authoritative and encompass every facet of medical care. Hence the leadership must be a composite one, emanating clearly from within our ranks. It is the medical profession which most clearly understands the truth concerning health matters. We must make every effort today to bring forth medical truths concerning total health care. For as Abraham Lincoln once said, "Truth is generally the best vindication against slander." ◄

302 N. Duke St.
Peru 46970

To the Editor:

It was with amazement that I read Dr. Lloyd Hill's call to arms to the conservatives. It is hard to realize that I graduated with this Cal Coolidge. (I thought it was in '53—he makes it sound like 1923).

I wonder where he has been since we graduated. Perhaps, like many physicians, he was spending a lot of time in the "counting chamber." Certainly he hasn't been trying to understand the times.

There may be nothing wrong with accumulating a fortune from the practice of medicine. It would be nice, however, to practice a little of this self praise we doctors heap upon ourselves—(remember kindly old doc in his horse and buggy or sitting up all night at the sick child's bedside ad nauseum).

I am sure Dr. Hill is one of the most dedicated doctors in Indiana. I simply wonder why all the concern with turning the political clock back to pre-revolution days.

If this sounds hard on Dr. Hill, I would like an explanation for all the nice names, e.g., leeches, that he called us liberals.

In the same issue (March, 1970) we have a similar-minded letter from Dr. Blazey. He and Dr. Hill blame all the world's ills on the actions of us liberals. Perhaps they should look to their own actions and worse; inaction when action was clearly called for.

How nice it is to know that all the world's ills are due to communists, socialists, long hair, sociologists, progressive education, the silence of the silent majority, social security, civil rights, medicare and fee assignments.

I hope these fine doctors sleep well knowing how righteous they are and how rotten we scrubby liberals are.

Sincerely,
R. J. DOHERTY, M.D.
Merrillville

Ethical Responsibilities

What is the extent of the physician's ethical responsibilities in referring a delinquent account to a collection agency?

According to an opinion adopted recently by the American Medical Association's Judicial Council, the physician—before referring any account to a collection agency—should give due consideration to the patient's ability to pay.

The physician should not utilize the services of a collection agency whose tactics and methods of collection might bring the medical profession into disrepute. Under no circumstances may he "sell" his delinquent accounts to a collection agency. In addition, the physician may not enter into any arrangement where he would lose complete control of the delinquent account or the method of its collection.

The Woman's Auxiliary

REPORTS TO ISMA

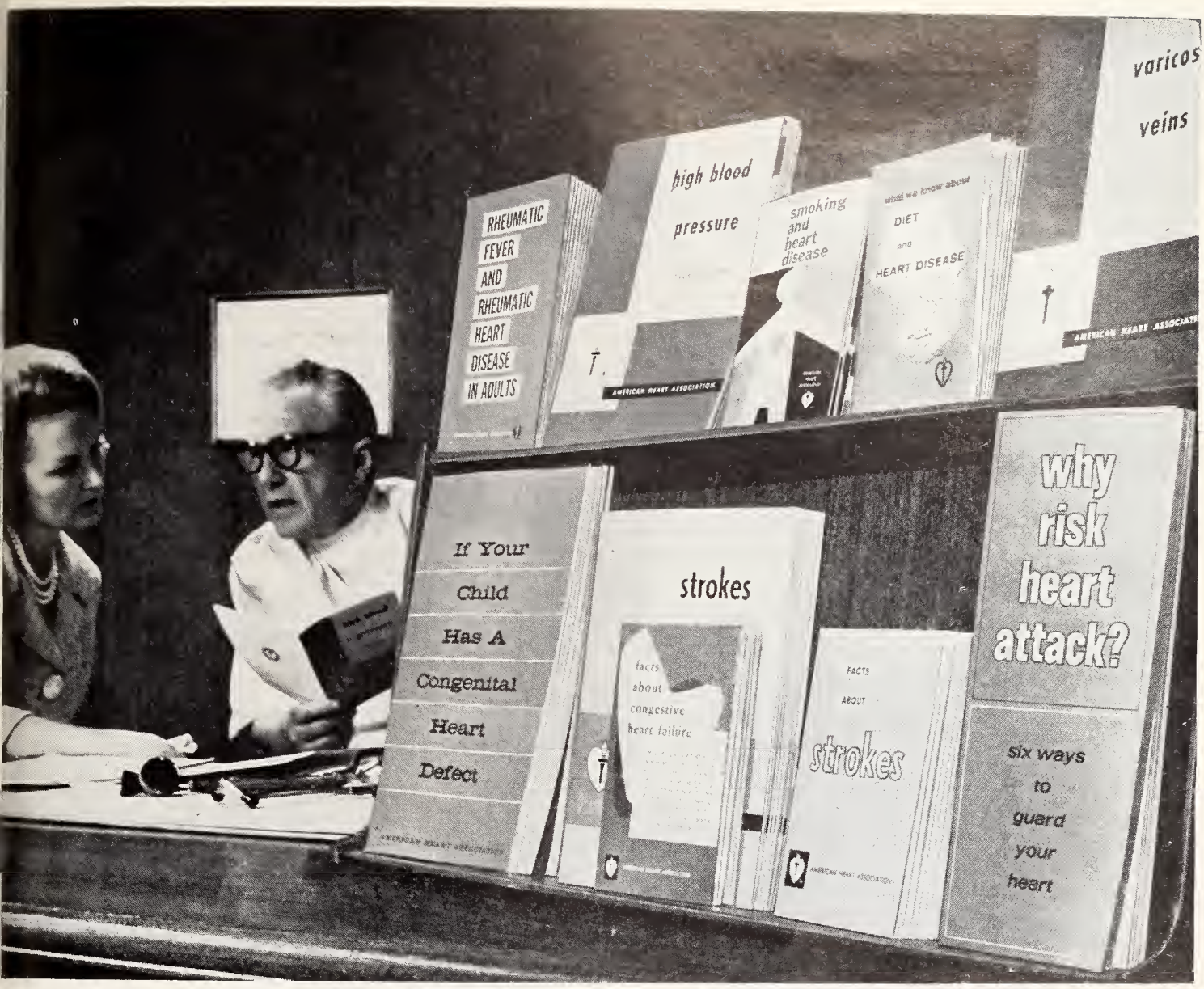
As president of the Indiana medical auxiliary, I was invited to attend many out-of-state meetings this past month. I was able to attend only one, the Woman's Auxiliary to the Illinois State Medical Society. I was treated royally and received many treats and a great deal of information. The program was beautifully planned and executed, and I certainly enjoyed it very much. The incoming president, Mrs. West, is using the theme of the 5W's—**W**omen **W**ho **W**ork **W**ill **W**in. This is a very clever and apropos theme. There certainly is a lot of wasted energy among women and what better way to expend it than to work for the health and welfare of our own communities?



Realizing the coming of summer months means more leisure time, we still can be thinking, and perhaps working, on some projects that will help our future in some way. There are so many things to be done and there is no one better qualified to do them than the physician's wife. We have our own programs from our national auxiliary to help us pave the way for our state and county auxiliaries and by using these guidelines and our own initiative, we will become happier and better wives and mothers and also more active auxiliary members.

If it were not for the constant encouragement from our medical societies, we would not be able to accomplish all the things we already do, but remember we can do more and we will.

Doris M. Clouse



Your Heart Association can help you help your patients

Your patients and their families might have questions about the heart and blood vessel diseases. Your Heart Association has prepared a variety of pamphlets to assist you in answering their questions in simple non-technical language.

Produced under the guidance of leading cardiovascular specialists, these pamphlets deal with such subjects as heart attack, stroke, hypertension, rheumatic fever, congestive failure, inborn heart defects, varicose veins and other disorders. There are also pamphlets advising on risk factors related to heart attack, including persuasive arguments against cigarette smoking, and a fat-controlled, low-cholesterol diet plan for the general public.

Booklets on therapeutic sodium-restricted or cholesterol-lowering diets are also available on a physician's prescription only.

Ask your local Heart Association for a catalogue listing all these free materials and order a supply.

American Heart Association

44 EAST 23rd ST., NEW YORK, N.Y. 10010

Contributed by the Publisher

What's New?

Elco Bio-Medical Equipment has introduced a new, inexpensive, simple-to-operate muscle stimulator for patients recovering from nerve injuries or diseases. It is a manually operated, battery-controlled, dependable device designed for patient use under supervision of physicians or therapists. There is a standard model and a special model for patients with manual dexterity problems.

* * *

Wyeth Laboratories, makers of S-M-A® Ready-to-Feed infant formula, is making it available in quart cans through the retail trade. It was supplied previously only to hospitals. The formula is concentrated, premixed, and presterilized. It is in a 20 calorie-per-ounce concentration and also contains iron and vitamins.

* * *

Taylor Instrument announces new sphygmomanometers containing conductive systems which eliminate a buildup of static electricity, making them safe for use in explosive atmospheres. They also have a newly-designed stethoscope for low frequency sounds and murmurs. The single tapered tube has a megaphone effect and comes in two lengths, regular and long. Taylor also has a new Tycos aneroid suitable for wall mounting which can be easily read anywhere in the room.

* * *

Mead Johnson is introducing a new over-the-counter product for use as a supplemental source of calcium and vitamin D. The new product is named Spar-Cal. It consists of an orange-flavored effervescent tablet which dissolves completely in six ounces of water and supplies 500 mg. of elemental calcium and 200 U.S.P. units of vitamin D.

* * *

Syntex is expanding its line of hormones from fertility control to the menopause. The new product, called Evex, is a purified, conjugated, orally active estrogen in the form of sodium estrone sulfate. It is marketed in tablets of three potencies, 0.625 mg, 1.25 mg, and 2.5 mg, each with different color-coating.

* * *

Smith Kline & French have announced that its Belgian subsidiary, Recherche et Industrie Therapeutiques, has been granted a license by the Swiss Federal Service of Public Hygiene for a vaccine to prevent German measles. It is made from the "Cendehill" strain and is grown in primary rabbit kidney cell cultures. Licensing arrangements have been started in the United States.

* * *

"The Allergy Cookbook," by Carol G. Emerling and Eugene O. Jonckers, has just been released by Doubleday. In 264 pages and for $5.95, one may learn all that Mrs. Emerling, whose whole family suffers from food allergies, including herself, has learned about the subject. Mr. Jonckers, at one time chef at the Voisin restaurant and at another time chef at the Savoy Plaza, adds the master's touch.

* * *

Veriflo Corporation has introduced the first clinical device to produce precise mixtures of oxygen and air for delivery to patients with an IPPB ventilator. A single control knob, calibrated from 21% oxygen to 100% oxygen, enables hospital personnel to select any desired concentration quickly.

* * *

"Insomnia: The Guide for Troubled Sleepers," by Gay Gaer Luce and Dr. Julius Segal, has just been published by Doubleday. It deals with what it is, can it be prevented or cured, and who has it? It is written both for the profession and for laymen. Drs. Walter Alvarez and Roy Menninger have approved the book.

* * *

A new diagnostic instrument for obstetrics, weighing only 7 lbs., is so sensitive it can detect fetal pulse as early as ten to twelve weeks. The Fairfield Fetone™ identifies multiple pregnancies as early as 20 weeks, locates the placenta at 26 weeks, and identifies umbilical flow, aiding early diagnosis and treatment of difficulties.

* * *

Fairfield Surgical & Medical-Electronics is marketing a metal rail which can be mounted in the wall of operating rooms, recovery rooms, and intensive care rooms, to which may be temporarily attached a variety of medical and surgical devices such as suction units, gas flowmeters, vaporizers, sphygmomanometers, I.V. stands, bed separators, tray holders or record trays. Brackets may be quickly attached to the rail for the mounting of apparatus, and may be easily moved as necessary. "Modura" is the trade name. Fairfield also markets the medical devices with mounting brackets for attachment to the rail.

* * *

Avon Printed Hospital Products has just introduced a new water soluble label called "Water-Sol" that is completely tamper-proof. The label is pressure-sensitive and can only be removed by washing away with water. It may be written on with pen, pencil or crayon, and will adhere even to oily surfaces.

* * *

Mead Johnson has added a new product to its line of infant formulas. Enfamil with Iron infant formula is dispensed in 32 fluid ounce cans. This size will furnish a full day's supply for most infants on a formula.

* * *

Schering has a new dosage form of Valisone, called Valisone Ointment. It is a companion product to Valisone Cream, and comes in 0.1% strength in 5, 15, and 45 gram tubes. The ointment is useful in the same conditions for which the cream is effective and is especially made for treatment of dry lesions of the skin.

Schering

After only one year:

Administered to more people than live in Hammond, Elkhart, and Lafayette.*



Injectable
Garamycin®
brand of gentamicin sulfate injection

*An estimated 208,000 patients have received GARAMYCIN Injectable to date. The combined population of Hammond, Elkhart, and Lafayette is 198,000. (Estimated 1969 figures from The New York Times Encyclopedic Almanac 1970.)

See Clinical Considerations section on last page

Mounting acceptance in the hospital...

Proven clinical effectiveness



Respiratory Infections

Outstanding results in serious gram-negative respiratory infections[1,2]

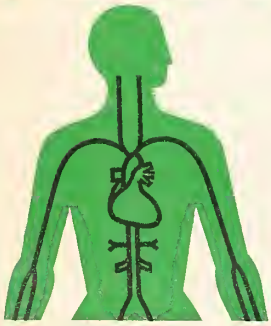
GARAMYCIN Injectable may prove successful where other antibiotics have failed.



Urinary Tract Infections

Strikingly effective in selected urinary tract infections[3]

With relatively low intramuscular doses, the promptly attained levels of GARAMYCIN achieved in the urine are considerably higher than the concentrations required for effectiveness against virtually all susceptible gram-negative pathogens. (Appropriate precautions are indicated in patients with impaired renal function; consult Package Insert for full details.)



Septicemia

May be lifesaving[4-6]

Numerous investigators have drawn attention to the value of GARAMYCIN Injectable in the treatment of gram-negative septicemias, often complicated by shock. Many hospital strains of *Serratia* are susceptible.[6]



Wounds and Burns

Response may be dramatic in wounds and burns complicated by sepsis[7]

The established efficacy of GARAMYCIN Injectable against *Pseudomonas*—as well as most other gram-negative pathogens—makes it an especially useful agent in the treatment of infected wounds and burns.

Important Precautionary Note Patients receiving treatment with GARAMYCIN Injectable (gentamicin sulfate injection) should be under close clinical observation because of the toxicity associated with the use of the drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal damage.

This drug should be limited to the treatment of serious infections caused by susceptible gram-negative bacteria, with due regard for relative antibiotic toxicity. (See Clinical Considerations section.)

Mounting evidence in the laboratory...

Schering

Over 95% gram-negative pathogens sensitive*

No other antibiotic performed comparably *in vitro* against gram-negative pathogens.
In a nationwide culture audit of antibiotic sensitivity patterns, sensitivity reports from 106 hospitals, geographically representative by census tract and of varying sizes, were analyzed. During the three-month period, ***every*** gram-negative culture slip from ***every*** hospital was surveyed. The total number of cultures involved in the audit was 97,091. The total number of sensitivity determinations was 643,503.

Pathogens	Percentage of sensitive strains / Number of strains tested — Antibiotics*							
	Garamycin	Kanamycin	Cephalothin	Cephaloridine	Ampicillin	Colistimethate	Chloramphenicol	Tetracycline
Klebsiella pneumoniae	99.5% 962	84.7% 992	86.2% 995	76.1% 67	32.7% 1,020	96.3% 640	82.9% 1,028	77.1% 1,026
Aerobacter aerogenes	95.9% 2,739	86.1% 2,818	53.5% 2,985	58.8% 1,514	22.7% 3,066	88.6% 2,603	85.8% 3,071	67.8% 2,981
Klebsiella aerobacter group	98.8% 566	83.9% 547	66.1% 522	60.5% 276	28.0% 553	89.5% 560	86.2% 587	62.8% 433
Klebsiella, all others	92.7% 2,944	83.3% 3,186	77.4% 2,976	67.5% 627	13.5% 2,883	95.0% 2,105	81.6% 3,212	70.6% 3,063
Pseudomonas aeruginosa	91.6% 4,528	29.8% 4,460	6.6% 4,418	6.6% 1,279	6.0% 4,360	91.3% 3,852	26.9% 4,608	26.4% 4,404
Proteus, indole-positive	91.8% 1,031	85.8% 1,062	39.9% 981	54.1% 364	40.2% 1,042	10.3% 758	76.1% 1,096	42.1% 1,051
Proteus mirabilis, indole-negative	94.9% 3,272	90.1% 3,378	83.1% 3,290	77.5% 975	78.0% 3,274	8.8% 2,634	85.9% 3,469	26.8% 3,278
Proteus, unspecified	96.2% 1,335	85.8% 1,371	71.7% 1,434	70.0% 647	64.7% 1,435	11.2% 1,233	76.0% 1,421	22.4% 1,298
Escherichia coli and all other *Escherichias*	96.4% 12,557	91.4% 12,818	87.8% 12,686	88.8% 4,251	74.6% 12,899	95.4% 10,623	94.1% 13,086	70.0% 12,559
Paracolobactrum, all	93.4% 303	88.9% 325	62.0% 305	74.2% 62	43.8% 340	80.9% 215	87.1% 350	72.6% 340
Coliform bacteria	99.0% 593	91.2% 649	81.5% 637	66.7% 21	52.7% 624	95.6% 607	91.6% 678	76.1% 637
Totals	95.1% 30,830	80.5% 31,606	65.3% 31,229	68.1% 10,083	50.3% 31,496	75.8% 25,829	79.7% 32,606	56.5% 31,070
Gram-positive (included for consistency with Package Insert, not an approved indication)								
Staph—*S. aureus*, coagulase-positive	97.4% 1,548	88.8% 1,458	97.7% 2,050	98.7% 636	61.1% 1,559	20.4% 628	94.4% 2,123	83.7% 1,966
Staph—*S. aureus*, unspecified	99.3% 993	92.8% 902	98.1% 1,289	95.3% 213	45.8% 1,153	29.3% 116	96.4% 1,427	82.3% 1,360

*Adapted from a three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).[8]
Antibiotics with significant gram-negative spectra are included. Organisms are listed as reported by laboratory.
Sensitivity testing was done by the disc method, a generally reliable test in the hospital setting. It should be noted, however, that the results with GARAMYCIN were somewhat higher than the results reported where the tube dilution technique was used. (See Clinical Considerations section which follows.) The concentration of the GARAMYCIN disc was 10 mcg.
Whereas standard testing methods were used by all hospitals, it is acknowledged that in a survey of this kind considerations such as differences in methodology are possible sources of error. The comparative percentage-sensitivity results derived from a survey of this kind are, therefore, not absolute. One should keep in mind also that the proper selection of an antibiotic is based not only on susceptibility testing but on relative toxicity and other clinical considerations as well.
It is felt, nonetheless, that the broad scope of the survey and the extreme care in data collection and tabulation permit a conclusion that the results are *generally* representative of current nationwide antibiotic sensitivity patterns.

Injectable Garamycin®
brand of gentamicin sulfate injection

See Clinical Considerations section on last page.

Injectable Garamycin®
brand of gentamicin sulfate injection

Schering

ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe 0.8-1.2 mg./kg. for 7-10 days	**Resistant/ Moderately Severe** Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	**Serious/ Life-Threatening** up to 5 mg./kg.
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†			
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentrations of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

Adverse Reactions: The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

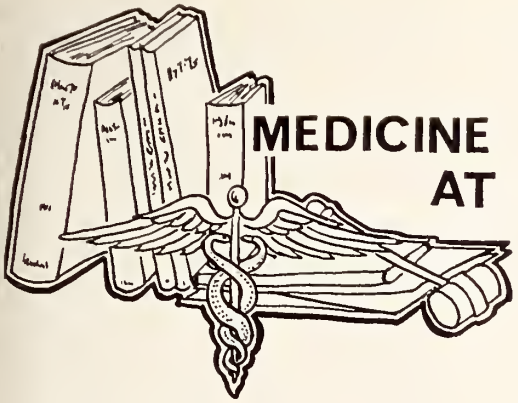
Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

References: (1) Brayton, R. G., and Louria, D. B.: Gentamicin in gram-negative urinary and pulmonary infections, Arch. Int. Med. *114*:205, 1964.* (2) Louria, D. B.; Young, L.; Armstrong, D., and Smith, J. K.: Gentamicin in the treatment of pulmonary infections, J. Infect. Dis. *119*:483, 1969. (3) Cox, C. E.: Gentamicin, a new aminoglycoside antibiotic: Clinical and laboratory studies in urinary tract infections, J. Infect. Dis. *119*:486, 1969. (4) Groll, E.: Clinical experience with gentamicin, data from 12 German clinics, in Gentamicin: First International Symposium, Paris, January 1967, Lucerne, Essex Chemie AG, pp. 121-128.* (5) Jackson, G. G.: Laboratory and clinical investigation of gentamicin, *ibid.*, pp. 62-74. (6) Medeiros, A. E.: Discussion, J. Infect. Dis. *119*:533, 1969. (7) Polk, H.: Discussion, J. Infect. Dis. *119*:529, 1969. (8) Three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).

*Dosage in this investigational study was less than now recommended in Package Insert.

For more complete prescribing details, consult package insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07083.



MEDICINE AT LAW

Hospital Suit Against Insurer Not Barred by Wife's Agreement—An insurance carrier was held by an Indiana appellate court not to be relieved of liability for medical expenses, despite approval of a written compensation agreement by the Industrial Board.

An employee was injured in the course and scope of his employment. A doctor, chosen by the employer, had the employee admitted to a hospital. At the time of his admission, the hospital submitted to the employer a "Request for Confirmation of Workmen's Compensation Benefits." This "Confirmation," authorizing hospital services for the employee, was signed by the employer. The name of the employer's insurance carrier was listed.

About five months later, the wife of the employee entered into an agreement with the employer for a weekly compensation. The wife had entered into this agreement as guardian of her husband, who was completely paralyzed and unconscious. Prior to this agreement she had been appointed temporary guardian for a period of 60 days. Although at the time of the agreement she was not in fact a guardian, the agreement was submitted to and approved by the Industrial Board. The Industrial Board then sustained the employers' petition for termination of its medical liability on the basis of the agreement. The employee died a few months later.

The employer's insurance carrier refused to pay for any hospital services after the date of the compensation agreement. The hospital contended that it had a contract for these services.

The court held that under the Indiana Workmen's Compensation Act the compensation agreement signed by the employee's wife had no force or effect. At the time of signing she was not in fact a guardian, and she would have authority to sign as a "dependent" only upon the death of the employee. The court therefore held that the hospital could recover for all of its services.—*Casualty Reciprocal Exchange v. Methodist Hospital of Indiana,* 252 N.E. 2d 517 (Ind., Dec. 1, 1969).

Club Dues and Expenses Partly Deductible—A physician's entertainment and club dues were held deductible to the extent that they were expenditures to preserve good will. The ruling was made by the Tax Court on appeal by the physician.

The taxpayer, a specialist in obstetrics and gynecology and also a professor at a medical school, maintains a full and busy practice. Approximately 50% of his patients are referred to him by other physicians.

In the years in question, the physician maintained memberships at two clubs, where he frequently entertained other physicians and their wives. Both clubs had facilities which were occasionally used by taxpayer and his family. From the evidence it appeared that the country club was used primarily for business entertaining but that the other club was not.

The Tax Court held that the entertainment expenses, including those of the wives, were properly deductible as expenses of furthering the physician's business by fostering good will, except for those occasions that did not meet the "quiet business meal" rule.

Since one club was not used primarily for business purposes, dues of that club were disallowed as a business expense. The dues at the country club were apportioned between business and personal use, and a percentage was allowed as a business expense.

Expenses of buying lunches for residents and interns at the hospitals where the physician performed surgery were disallowed because he failed to keep records to substantiate the expenses.—*Laforge v. Commissioner,* 53 T.C. No. 7 (Oct. 20, 1969).

Dog and Pony Raising Expenses Not Deductible; Orchard Expenses Deductible—A physician's expenses in raising dogs and ponies were considered hobby losses, whereas his apple orchard was considered a business.

The physician lived on a 10-acre farm, where he raised dogs and ponies. Each year he lost money and deducted the losses on his personal tax returns. He stated that he was in the business to make a profit, but the Tax Court held otherwise. The court felt that due to a busy practice he did not have the time that a genuine business would have required. It found that he had not paid such attention to the enterprise or seen to such promotion and advertising as would be consistent with a profit-making intent. Accordingly, the losses incurred in these activities were disallowed.

On the other hand, the physician had planted 800 apple trees on his property. This expense the court al-

Continued

lowed. It was persuaded by the magnitude of the operation and the fact the apple raising, unlike dog and pony raising, was not the type of activity generally consistent with recreational purposes.—*Currie v. Commissioner*, T.C. Memo. 1969-4 (Jan. 7, 1969).

Medicare Payments to Medical Faculty—Fees collected by physicians on the faculty of a medical school for the treatment of patients covered by Medicare, and turned over by them to the school, were not includable in the physicians' gross income, the Internal Revenue Service ruled.

The school supplies the physicians to a hospital for the purpose of rendering specified teaching services to residents, interns, nurses, and other hospital employees. In connection with those teaching services, the physicians provide medical care to indigent hospital patients, some of whom are covered by Medicare.

It is the medical school's policy that no faculty member is to receive fees for professional services rendered in the course of his teaching duties. Therefore, pursuant to an agreement with the school, the faculty physicians formed a group which billed and collected fees for services rendered by them to hospital patients covered by Medicare. After deducting the costs of collection, the fees were turned over to the school, which used them for purposes determined by the school.

Since the physicians at no time had any control over the fees, they were not required to include the amount thereof in their gross income.—*IRS Rev. Rul. 69-274*, I.R.B. 1969-22, 9.

New "Abortion on Demand" Law in Hawaii—Hawaii became the first state to permit abortion "on demand" when House Bill No. 61 became effective in March, 1970. The Governor permitted the bill, as passed by the legislature, to become law without his signature.

The law amends the Hawaii Revised Statutes by adding a new section to read as follows:

"Section—. Intentional termination of pregnancy; penalties; refusal to perform.

"(a) No abortion shall be performed in this State unless:

"(1) Such abortion is performed by a licensed physician or surgeon, or by a licensed osteopathic physician and surgeon; and

"(2) Such abortion is performed in a hospital licensed by the department of health or operated by the federal government or an agency thereof; and

"(3) The woman upon whom such abortion is to be performed is domiciled in this State or has been physically present in this State for at least ninety days immediately preceding such abortion. The affidavit of such a woman shall be prima facie evidence of compliance with this requirement.

"(b) Abortion shall mean an operation to intentionally terminate the pregnancy of a nonviable fetus. The termination of a pregnancy of a viable fetus is not included in this Act.

"(c) Any person who knowingly violates this section shall be fined not more than $1,000 or imprisoned not more than five years, or both.

"(d) Nothing in this section shall require any hospital or any person to participate in such abortion nor shall any hospital or any person be liable for such refusal."

The new law repeals Section 768-6 and 768-7 of the Hawaii Revised Statutes, which prohibited abortion "without lawful justification" and which permitted abortion only "for the purpose of saving the life of the woman."—House Bill No. 61 (March, 1970).

Radiologist Liable for Failure to Report X-ray Shadow—Evidence that a radiologist failed to report a shadow in the kidney area on an x-ray was sufficient for a jury to find the hospital guilty of malpractice, a New York appellate court ruled in affirming a jury verdict for the patient.

The patient entered the hospital complaining of a small cut on the back of her neck which refused to heal and of a pain in her lower back. X-rays were taken on the neck and the lower spinal region for the purpose of furnishing her physician with information relative to the diagnosis and treatment of those two areas. A shadow or density appeared in the area of the right kidney but was not reported by the radiologist.

Several months later a kidney stone was removed from the patient, and several years later an abscess required the removal of her kidney. The patient sued the hospital for malpractice in that it failed to report the x-ray showing of the density in the kidney. The jury returned a verdict for the patient.

The appellate court affirmed the decision of the lower court, holding that the jury had heard sufficient evidence to support its verdict.

A vigorous dissent was written by a judge who did not agree that there had been continuous treatment. The patient was at all times in the care of an attending physician who had no connection with the hospital. According to hospital records, she was dismissed from the hospital after the removal of a fibro-epithelial polyp. The continuous treatment rule requires treatment for the same or related illnesses or injuries continuing after the alleged malpractice. Since the patient was not in the hospital for a kidney ailment when the alleged malpractice occurred, the dissenting judge felt that, even though the patient subsequently returned to the hospital for treatment of her kidney problem, the continuous treatment

rule had not been satisfied.—*Capuano v. Jacobs*, 305 N.Y.S.2d 837 (N.Y., Dec. 4, 1969).

Physician not Liable for Failure to Diagnose Cancer—A physician who allegedly failed to discover breast cancer in a 59-year-old patient was not professionally negligent, a California trial court ruled. The woman claimed that five months after she discovered a lump in her breast, she told the physician who said she had simply gained weight. However, since she complained about her rib cage, he hospitalized her.

Eight months later, another physician performed a mastectomy and found malignant nodes and general metastasis. The court upheld the first physician's contention that the woman had not shown him the lump or made any complaints regarding it. He also claimed that the metastasis had started before the lump appeared. —*O'Connor v. Jolly*, Super. Ct., Los Angeles Co. (Cal., 1969).

Physicians Liable for Failing to Discover Cancer—An internist and a radiologist who allegedly failed to discover a cancerous tumor of the colon early enough to treat the condition were held liable for the death of a 32-year-old man in a suit by the widow and her three children.

The patient, who had been treated by the physicians for four years for ulcerative colitis, had a checkup six months before death. Sometime after the examination, the radiologist found a tumor in the colon, and surgery was performed. Five days after the operation, the man died as a result of surgical complications.

The widow contended that the radiologist was negligent in failing to detect the cancer at the patient's semiannual checkup and that, as a result, surgery was not performed until it was too late. She also claimed that the internist should have noticed changes in the patient's condition.

The internist argued that he was not negligent since he relied solely on the reports supplied by the radiologist. The radiologist testified that death was due to a fast-growing cancer which was nonexistent or microscopic at the time of the semiannual examination. Both physicians said the patient would have died even if surgery had been performed at an earlier date.—*Hill v. Geller and Moehring*, Super. Ct., Los Angeles Co. (Cal., 1970).

No Liability for Patient's Fall from Scale—An osteopath was held not liable in a suit by a woman who alleged that when, at his request, she stepped on the scales in his office, they fell forward, causing her to strike her head on a chair and break bones in her left hand. She charged that he was negligent in failing to anchor the scales and in having a slippery floor. The Indiana jury however returned a verdict for the osteopath.—*Indianapolis News*, Indianapolis, Ind., Jan. 8, 1970.

Patient Recovers for Negligent Treatment of Disc—A patient was awarded damages of $7,500 by a California trial court jury in her suit against a medical group for injuries resulting from its employees' negligent treatment of her disc condition.

The group had diagnosed the patient's back condition as a disc problem 11 years earlier and had treated it conservatively. The patient's expert medical witnesses testified that she had had a herniated disc and should have had a myelogram and surgery. The group claimed that the treatment which it gave was adequate and proper for the patient's condition.—*Baum v. Kaiser Foundation Hospital*, Super. Ct., Alameda Co., Docket No. 353270 (Cal., 1969).

Osteopath Denied Staff Privileges Because of Instability—The Board of Trustees of a public hospital did not act arbitrarily and capriciously in denying staff privileges to an osteopath, a federal trial court ruled. The evidence supported the Board's finding that the osteopath was so unstable as to make him a poor risk for staff membership.

The osteopath began practicing in the city in 1965. Shortly thereafter he was granted staff privileges at a hospital in the city which had only osteopaths on its staff. In 1967, he applied for membership on the staff of the public hospital. His application was denied because the bylaws in effect at that time limited staff membership to graduates of medical schools.

The public hospital eliminated the requirement of medical school graduation from its bylaws in March, 1968, thus opening staff membership to osteopaths. At the same time, a rerequirement of one year of residency training in a hospital was added to the bylaws.

The osteopathic hospital closed in September, 1968. Its six staff members, including the osteopath bringing this suit, applied for membership on the staff of the public hospital. The hospital staff recommended that all of the applications be denied because none of the osteopaths met the requirement of one year of residency training. The Board, acting under authority granted it by the bylaws, admitted all of the osteopaths, except the one bringing this suit, to the staff for a probationary period of one year. He was not advised as to why he was not admitted along with the other five osteopaths.

The osteopath contended that the Board's denial to him of staff privileges violated his constitutional right to equal protection of the law.

The Board owed a duty to the public to exercise care to see to it that the physicians using the hospital facilities were qualified to furnish adequate medical care to patients. The evidence established that the bylaws' requirements for staff membership, including the requirements as to residency training, were reasonably related to accomplishing that purpose, and that the residency requirement had not been inserted for the purpose of disqualifying the osteopath or anyone else but had been adopted as a

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AT LAW

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step toward securing accreditation for the hospital from the American Hospital Association.

Thus, in waiving the residency requirement, the Board had to have a reasonable basis for doing so. The Board relied on its personal knowledge of and acquaintanceship with the five osteopaths who were admitted, all of whom were well-established and respected citizens of the city.

The osteopath bringing this suit was not denied staff membership because of lack of qualifications as an osteopath or because of failure to meet the residency requirement. The Board denied him staff privileges because it concluded that he was so unstable as to be a poor risk for staff membership. Before coming to the city, he had practiced in seven other cities during a period of less than 15 years; he offered no explanation for the frequent moves. He saw on a daily basis what some members of the Board considered an excessively large number of patients, amounting in their opinion to practicing osteopathy on a mass production basis, possibly for the purpose of recouping financial losses that he had sustained. His earlier partnership with another osteopath had ended in litigation. He had had some difficulties with the authorities with respect to Medicare fees. He had furnished the Board with wholly inadequate information about himself in his application.—*Don v. Okmulgee Memorial Hospital*, Dist. Ct., Docket No. 68-207 (D.C., Okla., Jan. 8, 1970). ◄

WANTED: Physicians Locations

GENERAL PRACTICE

Ligon, Nicanor D., 2031 E. 73rd St., Chicago, Ill. 60649

Macatangay, Edelino L., 841 Mulberry St., Williamson, W. Va. 25661

Nalley, James, 704B E. Cedar, South Bend, Ind. 46617

Pugh, Phil, 727 18th St., Des Moines, Iowa 50314

Wilkins, Deiter, 1595 Kingswood Dr., Hillsborough, Calif. 94010

SPECIALISTS

EAR, NOSE, AND THROAT:

Harker, Lee Allen, 710 Woodside Dr., Iowa City, Iowa 52240

GENERAL SURGERY:

Barbarisi, Charles F., 215 Terrace Dr., Mankato, Minn. 56001

Christy, John P., 106th General Hosp., APO San Francisco 96503

Lorber, James M., 3525 Beeler Ave., Indianapolis, Ind. 46224

Nevin, James E. III, 990 Main St., Danville, Va. 24541

Wheeler, C. J. Jr., 148 Pleasant St., Apt #2, Marblehead, Mass. 01945

INTERNAL MEDICINE:

Dunkel, Thomas B., Box 244, Madigan General Hosp., Tacoma, Wash. 98431

Gozar, Alfonso G., 4365-A. Northfield Rd., Apt. 305, Warrensville Hts., Ohio 44128

Halpern, Samuel E., 11661 Montana Ave., #3, Los Angeles, Calif. 90049

Lynch, William E., 117 Arnold Circle, Biloxi, Miss. 39531

McAninch, James R., 2724 Pine Grove, Chicago, Ill. 60614

Pickett, John C., 227 Hayes Circle, Fort Ord, Calif. 93941

Tord, Jose N., 6503 Marsol Rd., Apt. 308, Mayfield Heights, Ohio 44124

OBSTETRICS AND GYNECOLOGY:

Yazdi, A. M., 1626 Morgan St., Keokuk, Iowa 52632

OPHTHALMOLOGY:

Turner, Jerald B., 911 Gaylemont Circle, Decatur, Ga. 30033

ORTHOPEDICS:

McCarty, David L., 3026 Eagle Pass, Louisville, Ky. 40217

PATHOLOGY:

Amorin, Jose V., 297 Center St., Bangor, Maine 04401

Ohl, Jordan, Major USAF MC, Dept. of Pathology, Wright-Patterson AFB, Ohio 45433

Urso, Frank P., 100 Beatty Rd., Media, Pa. 19063 ◄



you can hang on for a few more minutes, Doctor, n sure I'll sneeze again."

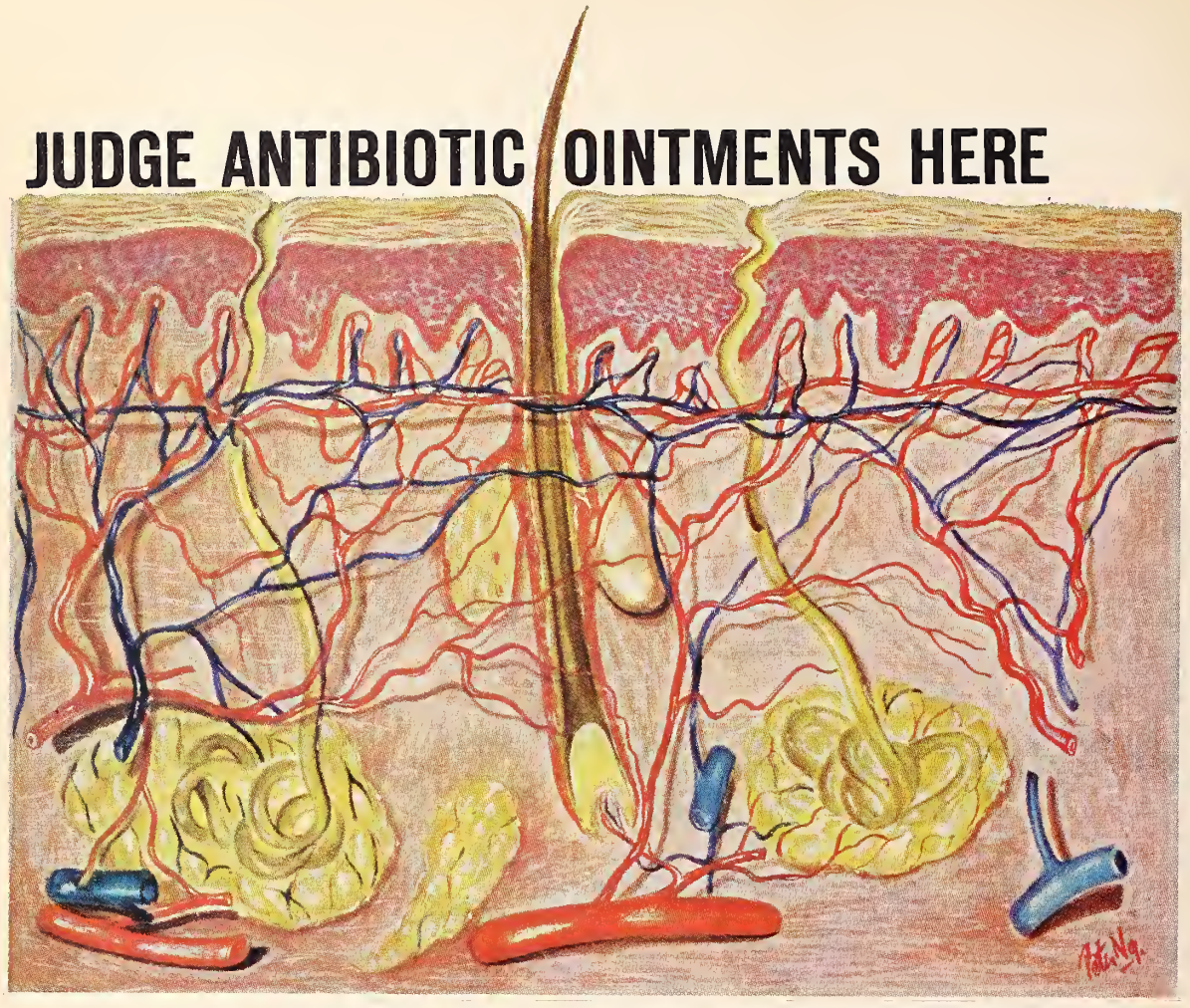
sneeze. And sneeze some more. But with Novahis- LP, most patients get prompt and long-lasting from the symptoms of allergies and colds. These inuous-release tablets have a vasoconstrictor-anti- mine formulation that begins working in minutes, continues to provide relief for hours. Even when congestion is due to repeated allergic episodes, Novahistine LP tablets, morning and evening, let most patients breathe freely all day and all night. Use with caution in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

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WARNING: Do not give in advanced kidney or liver disease. PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. DOSAGE: 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg tablets will usually correct spasm and leave a few tablets for a reserve.*

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It is summarized on this page.

Where there's no will there's a therapeutic way.

*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., *et al.: Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.: Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

Preludin®
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Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by mid-morning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.

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ABSTRACTS, BOOK REVIEWS

HANDBOOK OF PSYCHIATRY

Edited by Philip Solomon and Vernon D. Patch, Lange Medical Publications, Los Altos, Calif., 1969; 623 pp.; $7.00.

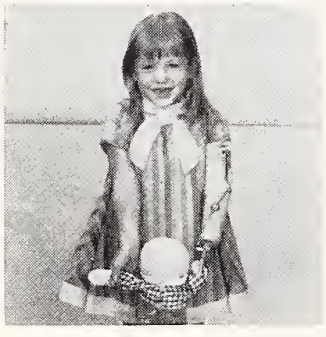
Handbook of Psychiatry, edited by Solomon and Patch, provides the family physician and internist with a concise, authoritative summary of the essentials of psychiatry in medical practice.

Choice of authors and of chapter divisions is admirable. Coverage is complete. The sections are well written and are as comprehensive as possible in a small compass. One of many examples of amazingly complete coverage in a small section is "Psychophysiologic Disorders" by Dr. Susan Kleeman.

References, usually presented under the headings of "Books and Monographs" and "Journal Articles," provide the physician with additional resources.

The relatively modest cost of the book, $7, makes it an essential for anyone interested in psychiatry and mental health—and certainly that should include every physician.

W. D. SNIVELY, Jr., M.D.
Evansville



The value of early fitting

Research has proven the fitting of prostheses on children should be accomplished as early as is practicable. It has only been a few years since the child amputee was not considered ready until just before pre-school age or even later. Extensive experience demonstrates that fitting at a much earlier age produces more effective results.
If there are no complicating factors, children with arm amputations usually should be provided with a passive type of prosthesis soon after they are able to sit alone, generally at about six months of age.
Lower-extremity child amputees should be fitted with prostheses as soon as they show signs of wanting to stand. The development of muscular coordination of child amputees is the same as for non-handicapped children; and, therefore, this phase may take place as early as eight months or as late as 20 or more months.
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ALCOHOL AND ALCOHOLISM

Gener Mariken, B.A., 5428 No. Virginia Ave., Chicago, Ill., 1969; pp. 98; $1.75.

Educating the public regarding the use of alcoholic beverages is today considered to be an important public health problem. It is so important that the W.C.T.U. has been reactivated—not to foster legislation as formerly—but for education, especially for the younger citizen. Alcohol is estimated to be the fourth most common cause of death. It contributes to bringing on death in many physical disorders. The suicide rate in alcoholics is 58 times that of the general population. Also it contributes prominently to deaths from traffic accidents and to death from fire, manslaughter and falling.

This booklet presents the facts concerning alcohol and its use and misuse. While the author is not a physician, the book is written in consultation with Eugene Scherman, M.D., who is a prominent physician in Chicago. It is divided into 14 chapters; it first discusses the methods of producing alcohol and gives its various uses—industrial, scientific, manufacturing, ceremonial and beverage. It presents the interesting history of the making of alcoholic beverages. Most alcohol is made pure or in beverage form from the fermentation of fruit or the distillation of fermented grain. The taxes on alcoholic beverages are one of the large sources of government revenue.

The main discussion of the book is on the abuse of alcoholic beverages, why people drink and why they become alcoholics. Some folks think, not as much now as formerly, that alcohol is a miracle drug, which is far from the truth. Also it is not a sex stimulant as some think. True it may remove some inhibitions but does not enhance the sexual act, and often does the opposite.

The author makes an interesting point regarding what factors and circumstances make the alcoholic. He concludes it is not the alcohol, but the basic makeup of the individual. Frequently alcohol leads to the use of more dangerous drugs. The alcoholic today is being looked upon as having a disease and not as a criminal and in more cities is being given psychiatric and pharmacological help instead of being put in jail to "dry out."

Especially of interest to young people is the chapter on how to avoid alcoholism. Everyone may have different problems regarding alcohol. The chapter, "When Not to Drink" presents valuable information and advice for younger individuals.

The booklet, which is clearly written and medically sound, is ideally suited to the teenager and also has much good information for older folks, but is not especially for physicians who should be previously informed on the subject. It contains several impressive pen sketches but no index. It should be in every high school library. The author very sensibly does not attempt to convey the idea that everyone who takes a drink is an alcoholic.

DAVID A. BICKEL, M.D.
South Bend

Abstracts From Various Literature, Prepared by AMA

WOLFF-PARKINSON-WHITE SYNDROME SIMULATING MYOCARDIAL INFARCTION

J. E. Smith, C. R. Harper, and G. J. Kidera (Medical Dept., United Air Lines National Airport, Washington, D.C.)
Aerospace Med. 41:328-330, (March), 1970.

During a routine company-prescribed physical examination, a

50-year-old airline captain was found to have an abnormal resting electrocardiogram and a positive post-exercise Master two-step test. Previous ECGs taken annually over a period of 18 years were normal. Reexamination showed a reversion to normal with a normal exercise ECG. It was decided that this case was an unusual type of Wolff-Parkinson-White syndrome and was not related to coronary heart disease. It is likely that exercise ECGs in the presence of Wolff-Parkinson-White type of accelerated conduction have no diagnostic value because of the frequency of false-positive tests.

USE OF HYPERBARIC OXYGEN IN TREATMENT OF CLOSTRIDIAL SEPTICEMIA COMPLICATING SEPTIC ABORTION

L. E. Perrin, D. R. Ostergard, and D. R. Mishell (Harbor General Hospital, Torrance, Calif.)

Amer. J. Obstet. Gynec. 106:666-668, (March 1), 1970.

A case of septic abortion complicated by *Clostridium welchii* septicemia and acute renal failure is presented. The patient was treated with preoperative hyperbaric oxygen at 2 atmospheres absolute pressure, antibiotics, total abdominal hysterectomy, and hemodialysis with almost complete recovery of renal function. The preoperative use of hyperbaric oxygen allows temporary and perhaps permanent improvement in the disease process.

PREGNANCY FOLLOWING CADAVER KIDNEY HOMOTRANSPLANTATION

R. M. Caplan, J. B. Dossetor, and G. B. Maughan (Royal Victoria Hospital, Montreal)

Amer. J. Obstet. Gynec. 106:644-648, (March 1), 1970.

The first successful human pregnancy following transplantation of a cadaver kidney is reported. Renal transplantation does not contraindicate vaginal delivery. No ill effects on the fetus from the use of immunosuppressive agents have been reported. The severe pulmonary problem encountered in the mother is attributable in part to the immunosuppressive drugs.

SURVIVAL IN ACUTE MYOCARDIAL INFARCTION BEFORE AND AFTER ESTABLISHMENT OF CORONARY CARE UNIT

D. K. Bloomfield, et al. (Mt. Sinai Hospital, Cleveland)

Chest 57:224-229, (March), 1970.

The therapeutic result in acute myocardial infarction for two periods immediately preceding (pre-CCU) and after (post-CCU) establishment of a coronary care unit were compared. One hundred cases of proved myocardial infarction were selected at random from each time period. Gross mortality was reduced from 33% pre-CCU to 16% post-CCU, most striking in the inferolateral infarct, 33% to 11%. Anteroseptal infarction mortality was reduced from 33% to 21%. The major reduction in mortality in the post-CCU series occurred in the first six days. The arrhythmias observed more frequently in the post-CCU series were ventricular ectopic beats, ventricular tachycardia, and complete heart block. Other arrhythmias were noted with equal frequency in both series. Sinus tachycardia and supraventricular tachycardias were associated with a high mortality rate in both groups. Ventricular tachycardia had a better prognosis than sinus tachycardia in the monitored series. In both groups, arrhythmias presenting after the first 72 hours were associated with a higher mortality.

INFLUENCE OF TETRACYCLINE AND CHLORAMPHENICOL ON HEALING OF CUTANEOUS WOUNDS

G. P. Bloom and H. C. Grillo (Harvard Medical School, Boston)

J. Surg. Res. 10:1-5, (Jan.), 1970.

The effects of two commonly used antibiotics, tetracycline and chloramphenicol, with their main mechanism of action the inhibition of protein synthesis, on the rate of gain of tensile strength in healing wounds were investigated. No significant differences from control were observed unless the dose of drug used was severely toxic, as measured by the failure of the test animals to gain weight. These drugs may be used in treating surgical patients without the danger of adversely affecting the healing of their wounds; the fibroblast system is less sensitive to these drugs than are other types of tissue.

COLLABORATIVE ANALYSIS OF LONG-TERM ANTICOAGULANT ADMINISTRATION AFTER ACUTE MYOCARDIAL INFARCTION

International Anticoagulant Review Group (D. D. Reid, London School of Hygiene and Tropical Medicine, London)

Lancet 1:203-209, (Jan. 31), 1970.

An analysis has been made of the records of 2,205 men and 282 women included in nine controlled trials of long-term anticoagulant therapy after infarction, carried out during a 15-year period. The mortality experience of "anticoagulant" and "comparative" series, which were shown to be alike in relevant clinical characteristics,

Continued

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was significantly lower (by 20%) in males given anticoagulants. The difference between the corresponding female groups could have arisen by chance. The apparent benefit in men seems to be restricted to patients reporting, at admission to these trials, either prolonged angina or previous infarction.

CONTROLLED TRIAL OF AMANTADINE HYDROCHLORIDE IN PARKINSON'S DISEASE

J. D. Parkes et al. (King's College Hospital, London)

Lancet 1:259-262, (Feb. 7), 1970.

A double-blind, cross-over trial of amantadine hydrochloride, 200 mg daily, and placebo, each given for two weeks, was conducted on 37 outpatients with Parkinson's disease. Thirty-five patients completed the trial and gave a highly significant preference for amantadine. Features of history and examination were assessed by standard questionnaire and all features showed a significant improvement in score on amantadine, except for the patients' assessment of their walking ability and the observers' examination of rigidity. The degree of improvement was not related to age, sex, duration or severity of disease, previous thalamolysis, or concurrent medication. Amantadine is probably similar in its mode of action to L-dopa, and although the amount of benefit may be less with amantadine, the drug was free of side effects and was well tolerated.

STUDY OF SUITABILITY OF HOLLOW SCREW FOR ADMINISTRATION OF INTRA-OSSEOUS TRANSFUSIONS IN EMERGENCY CASES: PRELIMINARY REPORT

H. F. Dankmeijer and M. Wijnans (Rijksuniversiteit, Leiden, Netherlands)

Nederl. T. Geneesk 114:47-51, (Jan. 10), 1970

The administration of transfusions through an intra-osseous screw, inserted into the sternum or elsewhere, to patients who are in severe shock offers considerable advantages in cases of emergency outside the clinic, at arrival in the hospital as well as in the ward. On the basis of anatomical and functional studies carried out in the cadaver, a hollow screw has been tested, which can be inserted at the level of the third intercostal space into the sternum or into the two medial tibial malleoli. So far the results have been promising.

POLYCYTHEMIC DONORS— ARE THEY USEFUL AND SAFE?

G. A. Hyman and E. Carlsen (Francis Delafield Hospital, New York)

Transfusion 10:10-13, (Jan.-Feb.), 1970.

A 15-year experience with the transfusion of blood from donors with polycythemia vera shows that for no valid scientific reason a fine source of donor blood has been ignored for many years. Not only has the expected benefit occurred following transfusion from polycythemic donors, but there has been freedom from possible adverse late sequelae; 56 recipients have lived from 2 to 13 years with 20 still being followed up. In no instance was a new case of cancer or of polycythemia vera discovered in the recipient. Cancer may occur less often than expected in the recipient of such transfusions. The authors suggest the healthy donor with polycythemia vera be employed routinely in the future.

RELATIONSHIP OF STARLING-BLACKBIRD ROOSTS AND ENDEMIC HISTOPLASMOSIS

F. E. Tosh et al. (2002 West 39 St., Kansas City, Kan.)

Amer. Rev. Resp. Dis. 101:283-288, (Feb.), 1970.

Histoplasmic skin test surveys of school children in two cities having large blackbird roosts positive for *Histoplasma capsulatum* revealed a significantly higher percent reactors to histoplasmin than was observed in two nearby cities not having bird roosts. Prevalence of histoplasmin skin test sensitivity was highest among children residing or attending schools near the roosts. The prevalence was greater among children who lived on farms than among those who had not except for children living near a bird roost. Urban blackbird roosts harboring *H capsulatum* contribute significantly to the prevalence of sensitivity to histoplasm of residents of the community.

HISTOLOGICAL MODIFICATION OF FIBROADENOMA OF BREAST ASSOCIATED WITH ORAL HORMONAL CONTRACEPTIVES

J. M. Brown (Box 14, Rundle St. P.O., Adelaide, Australia)

Med. J. Aust. 1:276-277, (Feb. 7), 1970.

A fibroadenoma of the breast, occurring in a 25-year-old woman, exhibited unusual features which are thought to be associated with the taking of oral hormonal contraceptives. Histological appearances were quite different from those of the ordinary fibroadenoma. With the widespread use of the "pill" and the common occurrence of fibroadenoma, the changes described would be expected to occur more frequently.

POST-TRAUMATIC ACUTE ACALCULOUS CHOLECYSTITIS IN YOUNG MALES

R. C. Shaw (Brooke General Hospital, Fort Sam Houston, Tex.)

Milit. Med. 135:210-214, (March), 1970.

Acute cholecystitis may occur in young men who are severely injured, who have become dehydrated, who have been fasting, and who have been receiving drugs such as atropine, meperidine, and opiates. Six histologically proved and two clinically suspected cases of acute acalculous cholecystitis in severely injured young men are presented to facilitate understanding of this surgical emergency.

NORMAL MENTAL DEVELOPMENT IN TREATED PHENYLKETONURIA

D. Lonsdale and M. Foust (Cleveland Clinic, Cleveland)

Amer. J. Dis. Child. 119:440-446, (May), 1970.

This report concerns experience obtained in the management of ten patients with hyperphenylalaninemia detected by the newborn screening program in Ohio. Nine of the infants were treated with a diet. Emphasis is placed on the first year of treatment and the danger of serum phenylalanine concentrations (SPC) in the physiological range. Clinical measurements of height, weight, and head circumference are sensitive indicators for phenylalanine starvation and, when related to the SPC, clearly indicate the rapidly increasing needs of the individual child during the first half year of life. As the need decreases, the SPC begins to rise, and the dietary allowance of phenylalanine diminishes. A diagnosis of hyperphenylalaninemia places emotional pressures on the parents which may influence their relationship with the child and create problems in assessment of his mental development. ◄

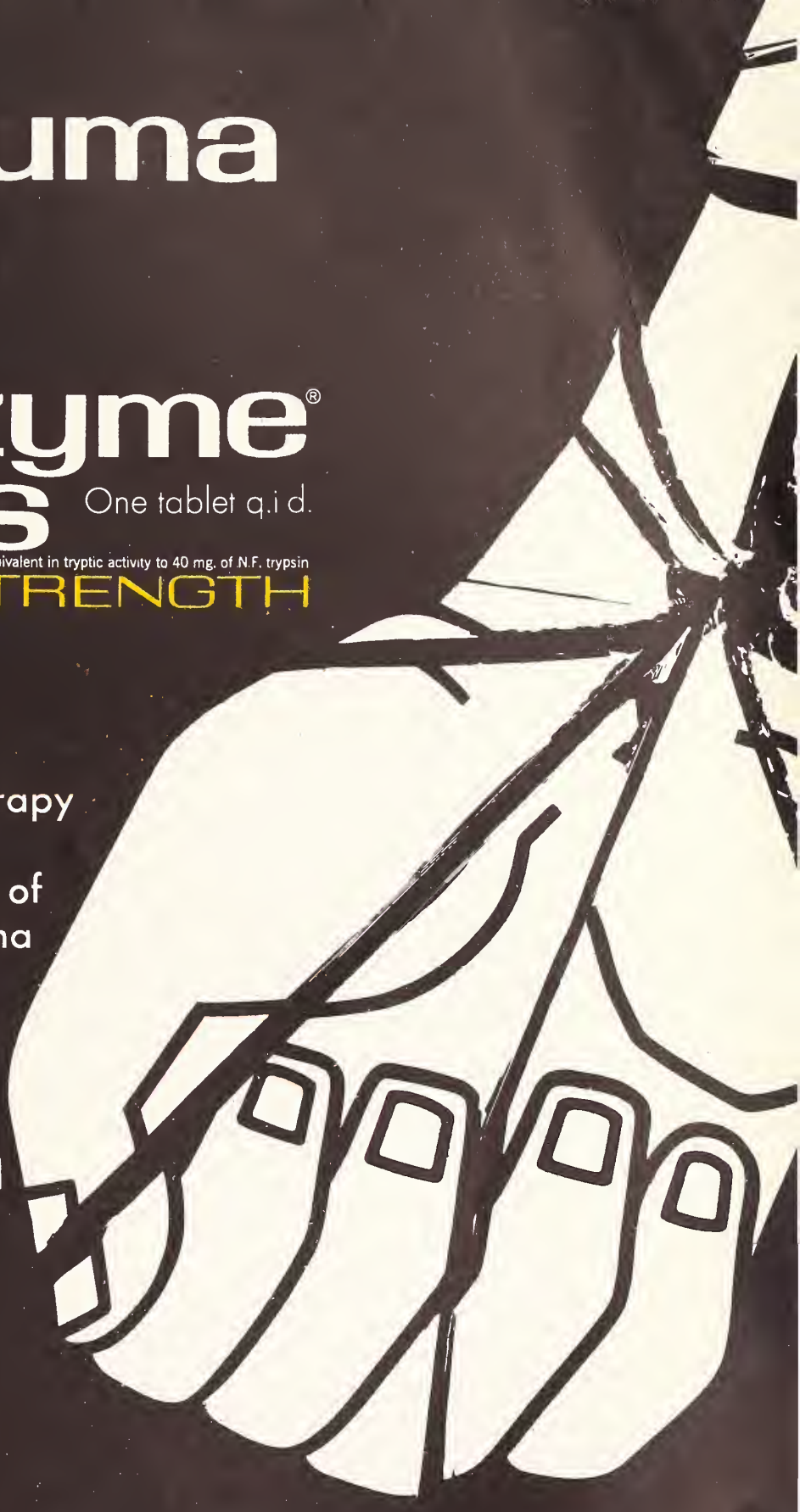
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- ☐ Postoperative Tissue Reactions.

Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

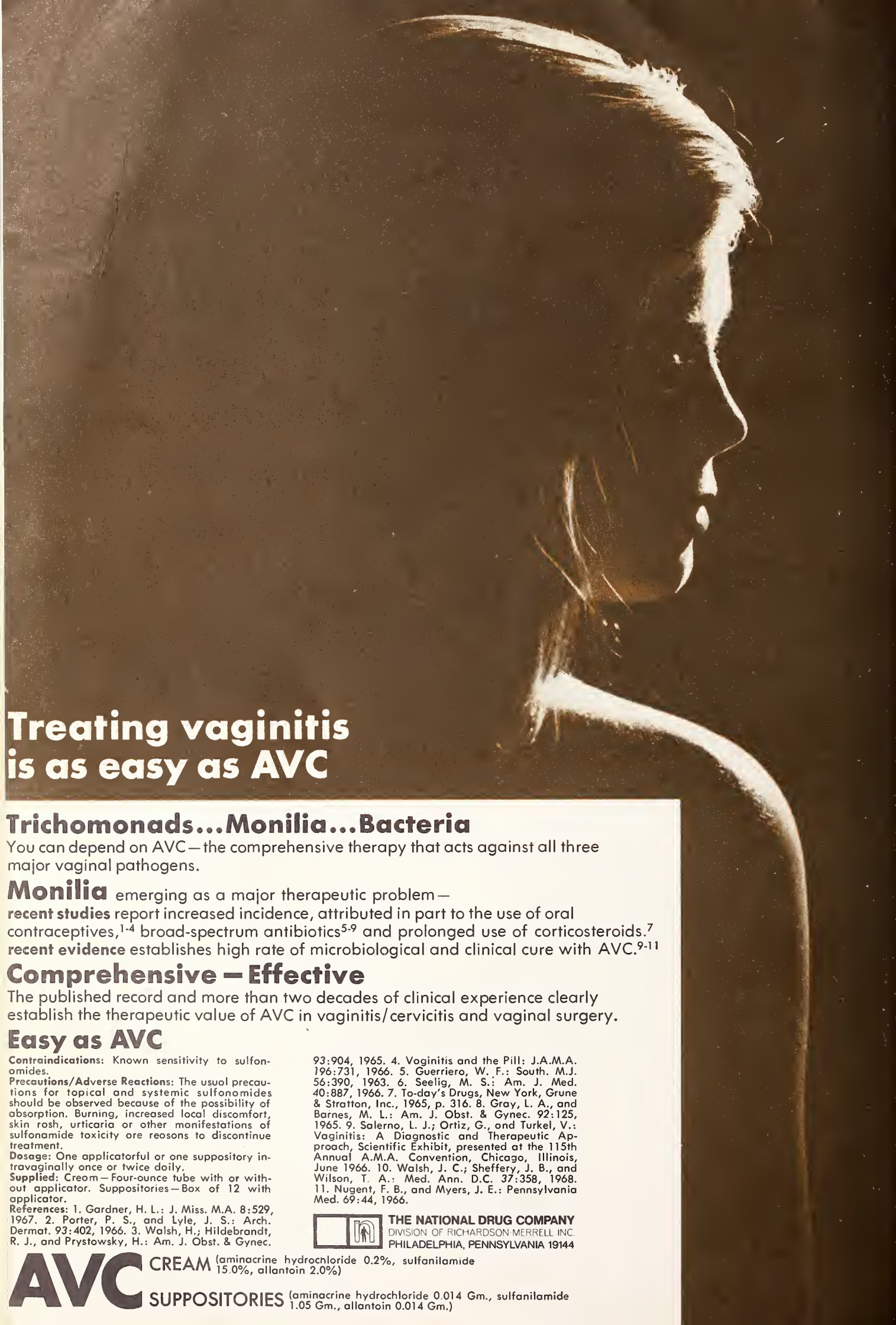
Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.

Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

Dosage: One tablet q.i.d.

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Contraindications: Known sensitivity to sulfonomides.
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Dosage: One applicatorful or one suppository intravaginally once or twice doily.
Supplied: Creom—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Voginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., ond Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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(One of a Series)



H. P. Dixon
Vice President



G. R. Miller
Field Manager



F. D. Harbridge
Representative



G. R. Parish
Representative



L. J. Coleman
Representative



J. D. Martin
Representative

Indiana Blue Shield Professional Relations has been expanded and reorganized in order to serve better the physicians of Indiana and their medical assistants.

The staff is now divided into a field staff and an internal information and service staff, each concentrating on solving problems for physicians. The field staff will be discussed in this article, with the relatively new internal staff to be the subject of next month's article.

Both the field staff and the office staff are part of the Professional Relations staff headed by Herbert P. Dixon, Vice President, who has been with Blue Shield for six years. He lives with his wife Jo Ann and their two children at 1415 Brewster Road, Indianapolis. Dixon attended Wabash College and is a Butler University graduate. He has an A.B. in political science and an M.S. in administration. His hobbies include the stock market and tennis.

Field Manager, in charge of four representatives who work directly with physicians and their offices, is Gary R. Miller, who has been with Blue Shield for two years. Miller and his wife Vicki live at 6046 Crestview Avenue, Indianapolis. Miller attends Butler University and his hobbies are music and sports.

Representative Frederick D. Harbridge has been with the plan three years. He and his wife Jan live at 110 N. Third Street, Zionsville, and they have one child. He attended Franklin College and Indiana University.

Representative George R. (Randy) Parish Jr., the bachelor on the staff, has been with Blue Shield for more than a year. A resident of 5414 Scarlet Drive, Indianapolis, he attended Wabash College and Indiana University, and is a graduate of Butler University. His hobbies are sailing and rifle marksmanship.

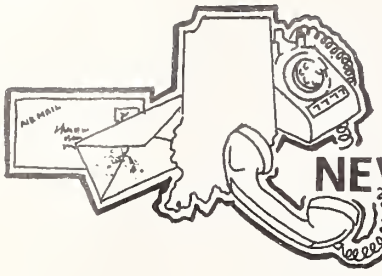
Representative Larry J. Coleman joined Blue Shield last December. A graduate of Indiana University in marketing, he was formerly employed by Baxter Laboratories and Ryker Dental Depot, Inc. He resides in Martinsville with his wife Karen and they have one child. Coleman likes to hunt, fish, camp and play golf.

The newest member of the Professional Relations field staff is Jerry D. Martin, who joined Blue Shield in April. He lives at 9744 Trilobi Drive in Indianapolis with his wife Linda and one daughter. Martin is a graduate of Indiana University. His hobbies include bowling, furniture refinishing and gardening.

Backing up the field staff are three able young ladies. Sandy Koker has served as secretary to Mr. Dixon since October, 1966. She attended Indiana University. Secretary to Mr. Miller is Sally Martz, who attended Indiana State University before joining Indiana Blue Shield in February, 1968. Secretary to the field representatives is Linda Buis, who attended Indiana University. She joined Blue Shield in February, 1969. ◄



Secretarial Staff, from left, Miss Buis, Miss Martz, and Mrs. Koker.



NEWS NOTES

Legal Opinion

The Indiana State Medical Association has received an opinion from its legal counsel to the effect that no legal liability may be attached to any physician who testifies, as a member of a committee of a county medical society, as to the committee's finding on the question of reasonableness of a medical fee. The legal opinion also stated that such testimony would be considered as expert testimony and that a reasonable expert witness fee could be expected.

Dr. Cullen Closes Office

Dr. P. Kent Cullen has closed his office at 310-311 Hume Mansur Bldg., Indianapolis, effective immediately. Dr. Cullen has left to join the staff of the Sansum Medical Clinic at Santa Barbara, Calif.

Dr. Poncher Elected

Dr. John Poncher, Evansville, has been elected vice president of the board of directors of the Porter County United Fund.

Committee Members

Dr. W. D. Hart, Anderson, and Dr. William VanNess, Summitville, were members of the Groundhog Committee of the Voiture 510 of the 40 and 8 which planned the annual Groundhog Club banquet held recently at Anderson. The banquet is sponsored by Madison County Voiture 510 in order to raise funds for its continuous program of financing the training of student nurses. **Dr. John C. Drake** was banquet chairman and **Dr. P. T. Lamey** is national 40 and 8 nurses' training program director.

Dr. Leslie W. Freeman Memorial Research Fund

A memorial research fund has been established in honor of the late Dr. Leslie W. Freeman, a member of the Indiana University School of Medicine faculty, who was an international pioneer in the treatment of spinal injuries.

The fund will be used to support research that will continue Dr. Freeman's research toward a method for restoring severed spinal cords, research which Dr. Freeman began as an Army surgeon during World War II.

Contributions may be made to the L.W. Freeman Memorial Fund in care of the Department of Neurosurgery at the I.U. School of Medicine or the Indiana University Foundation in Bloomington.

Dr. Backer Honored

Dr. Barbara Backer, LaPorte, has won the Jaycee Outstanding Citizen Award for her dedication to health causes in LaPorte and LaPorte County. Dr. Backer is the first woman to ever win the award.

Conducts Tour

Dr. Gabriel J. Rosenberg, Indianapolis, conducted a tour of cystic fibrosis facilities at the Methodist Hospital Children's Pavilion recently as part of the ninth annual meeting of the central Indiana chapter of the National Cystic Fibrosis Research Foundation.

Physicians on Panel

Drs. Louis Spolyar and **Henry Nester, both of Indianapolis,** appeared on a panel discussion of leprosy recently as part of the city's observation of "World Leprosy Day." Dr. Spolyar is commissioner for medical operations of the Indiana State Board of Health and Dr. Nester is county health officer.

Pfizer Announces 12 Four-Year College Scholarship Winners

Pfizer Inc. has announced the 1970 winners of 12 college scholarships granted to children of employees who plan to study science, engineering, business or liberal arts. Six of the students are Pfizer Merit Scholars and six are winners of the newly created John E. McKeen Scholarships, established by Mr. John E. McKeen, honorary chairman of the board and retired board chairman and president of Pfizer. Both scholarship programs are administered by the National Merit Scholarship Corporation and provide four-year financial assistance at the college of each student's choice.

Two of the winners are Hoosiers: Terry L. Watkins, Pfizer Merit Scholar, Sullivan, Ind., plans to major in mathematics at Rose Polytechnic Institute. His father, Ralph V. Watkins, is a foreman at Pfizer's Terre Haute plant.

Kenneth E. Kahl, John E. McKeen Scholar, St. Marys of the Woods, Inc., will major in chemistry at Rose Polytechnic Institute. His father, Joseph H. Kahl, is a Pfizer stationary engineer.

Named to Posts

Dr. Paul Honan, Jr., Lebanon, has been re-elected chairman of the board of the Boone County YMCA. **Dr. Fuad Mukhtar, also of Lebanon,** was named to the World Service Committee.

I.U. Trustee Honored

Marion physician Dr. Merrill Davis was among past trustees of Indiana University honored recently during opening services of the university's 150th anniversary in Bloomington.

Dr. Juergens Speaks

Dr. Richard Juergens, Fort Wayne, discussed Africa at a recent general meeting of the WSCS of Faith United Methodist Church at Churubusco. Dr. Juergens and his wife spent two months relieving a missionary doctor in Africa two years ago.

Dr. Waitt Narrates

Dr. Paul Waitt, Noblesville, spoke of his volunteer service in Viet Nam recently before a meeting of the Noblesville Kiwanis Club.

Patients Needed by I.U. for Clinical Research Studies

Patients in the following disease categories are needed for clinical research studies presently being conducted at the Indiana University Clinical Research Center:

1. Hypoparathyroidism—either surgical or spontaneous.
2. Pseudohypoparathyroidism.
3. Sarcoidosis, particularly patients with hypercalcemia or renal stones.
4. Renal diabetes insipidus—either adults or children.

The studies would involve admission to the Clinical Research Center for periods of from one to two weeks for metabolic

balance studies and would involve no expense to the patients.

Physicians wishing to obtain further information or to refer patients please write Dr. Norman H. Bell or Dr. Charles M. Clark, Jr., Division of Endocrinology, Indiana University Medical Center, Indianapolis, Indiana 46202 or call 317-635-7401, Ext. 264.

Annual Meeting Speaker

Dr. Hanus J. Grosz, Indianapolis, participated in the annual meeting of the American Psychiatric Association recently by introducing a panel of six mental patients and ex-psychoneurotics, members of Recovery, a national self-help organization. The panelists demonstrated their organizations' self-help techniques. There are more than 800 volunteer groups in the U. S. and Canada, each with a group leader, organized to assist patients on the road to recovery.

Dr. Chalian Speaks

Dr. Varoujan Chalian, chairman of the Department of Maxillofacial Prosthetics at Indiana University School of Dentistry, participated in the annual clinical session of the Czechoslovak Medical Society recently. The I.U. department is the only full-fledged department of its kind in an American dental school. Dr. Chalian's specialty is the modeling and fitting of artificial eyes, ears, noses, cheeks, jaw bones, and other devices for functional and/or cosmetic purposes.

Joins Conference

Dr. John U. Keating, Indianapolis, took part in an all-day conference on drug use and abuse held recently in the Indiana University Auditorium at Bloomington.

Dr. Branam Speaks

Dr. George Branam, Muncie, was the keynote speaker at a Teacher's Workshop on Smoking and Health held recently in Anderson. Dr. Branam's subject was "The Effect of Smoking on the Human Body."

Dr. Poehler on Panel

Dr. Fred Poehler, LaFontaine, represented the medical profession on a panel discussion on "Current Problems in Consumer Protection" which was the topic for the fourth annual Manchester College Health Conference held recently on the Manchester campus.

On TV Show

Drs. Herschel C. Moss and Neil Strickland, both of Indianapolis, appeared along with two ministers on Visit With Vivian, an interview-type show carried in Greenfield. The two physicians, members of Voluntary Sterilization Association of Indiana, Inc., discussed abortion laws, sterilization and the church and the problems that must be solved.

Barbecue Fire Safety Topic of New NFPA Film

Barbecue fire safety is the topic of the new film "It's Time to Light the Fire," now available from the National Fire Protection Association (NFPA).

This 11-minute 16mm production in full color and sound demonstrates the important "do's and don'ts" of handling the barbecue fire, from start to finish.

One particularly strong sequence covers the dangers of using liquid starters to freshen a burning fire, shows the various types of starters available, and demonstrates safety precautions needed for each type. Other scenes point up the special hazards of barbecue fires on porches, balconies and closed-in spaces, emphasize the clothing fire hazards of cook-outs, and remind viewers to keep small children at a safe distance from any barbecue fire.

Informative in an entertaining way, "It's Time to Light the Fire" provides a service opportunity for delivery of an important home fire safety message by many groups—fire departments, insurance companies, civic organizations, industrial firms, government agencies, utility companies and others. The film was produced by Film Communicators with technical assistance from NFPA.

"It's Time to Light the Fire" is available at $130 per print from the NFPA Publications Service Department, 60 Batterymarch Street, Boston, Mass. 02110.

Dr. Hall Appointed

Dr. Jack H. Hall, director of medical education at the Methodist Hospital in Indianapolis, has been appointed assistant dean of the Indiana University School of Medicine. He will be responsible for the education, research, and service affiliations between Methodist Hospital and the Medical Center.

Dr. Young Honored

Dr. John E. Young, Indianapolis, was honored recently by Wayne State University School of Medicine. Dr. Young and about 50 members of his 63-member class returned for celebration of their 25-year anniversary.

Attend Meeting

Drs. Joel Salon of Fort Wayne and D. Edmund Storey of Indianapolis attended the fourteenth annual meeting of the American Society of Internal Medicine at Philadelphia, Pennsylvania, recently as delegates from the Indiana Society of Internal Medicine. The theme of the meeting was "Social and Economic Conditions Affecting the Delivery of Medical Care."

Purdue University Undergraduate Wins Top National Student Award

For the second year in a row, a Purdue University undergraduate has won one of the top national student awards in pharmacy.

Garre E. Blair, Albany, Indiana, is the recipient of the 1970 Kilmer Prize. This is awarded annually for the best paper based on research in pharmacognosy by a member of the graduating class of one of the 74 accredited colleges of pharmacy. Last year, Bruce H. Mock, Columbus, Indiana, won the Kilmer.

Speaks on Drugs

Dr. Howard Jackson, Madison, discussed the effects of dangerous drugs and narcotics on the human body recently before a meeting of teachers from the North Spencer School Corporation at Clay City.

Dr. Rifner Named

Dr. E. S. Rifner, Van Buren physician and president of the Grant County Medical Society, has been named to represent the society on the Grant County Drug Council.

Speaks for Auxiliary

Dr. John Slaughter, Evansville, spoke at a recent meeting of the Vanderburgh Southwestern Medical Auxiliary at St. Mary's Hospital. Following his talk, there was a workshop at which drugs and supplies were packed for his "Holidays for Humanity" project.

Continued

Dr. Tetrick Speaks

Dr. E. Lain Tetrick, Portage, spoke on the topic of "Have a Heart" at a meeting of the Chesterton Women's Club recently. Dr. Tetrick showed slides to highlight points of interest of his program.

Dr. Wagner Chairman

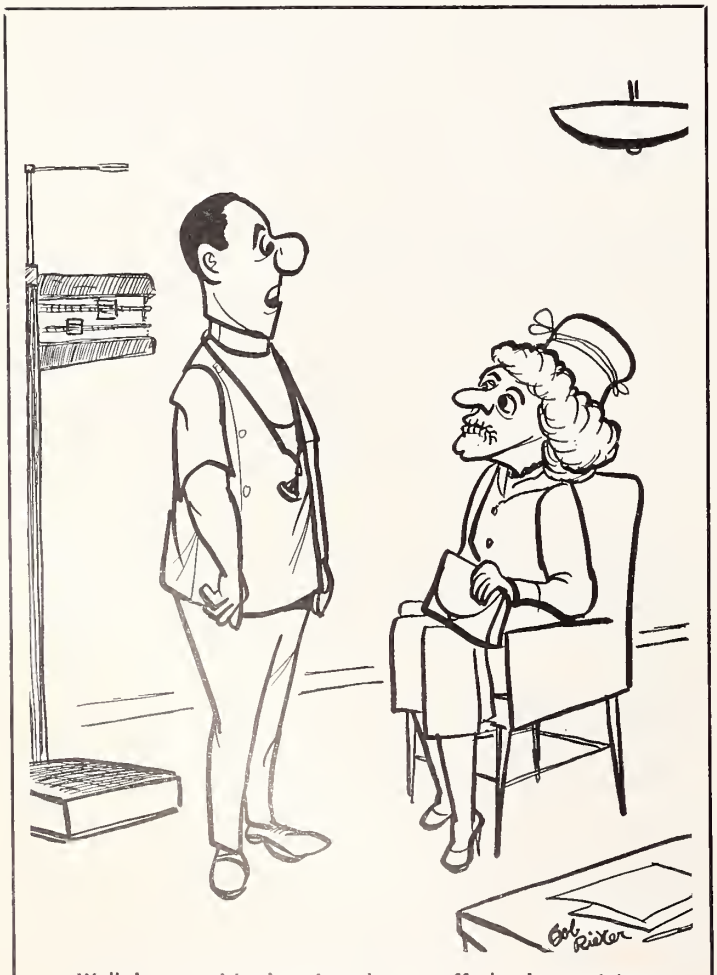
Dr. Lindley Wagner, Lafayette, was a conference leader recently for the Tippecanoe County Red Cross chapter Disaster Nursing Session. Dr. Wagner is disaster medical chairman for the group.

Dr. Griffin Chosen

Dr. Charles Griffin, Valparaiso, was recently chosen as chairman of the Medical Advisory Committee of the Visiting Nurses Association of Porter County.

Addresses Meeting

Dr. Frank W. Peyton, Lafayette obstetrician, recently addressed the Married Fellowship meeting at Purdue University. His topic was "Abortion."



Well I guess it's time I took you off the lemon juice!

Dr. Bundy New President

Dr. Merle Bundy took office recently as president of the Industrial Medical Association during its annual meeting in Chicago.

Dr. Bundy was graduated from Indiana University School of Medicine in 1942. He was Chief of Tuberculosis Control for the Indiana State Board of Health for several years before going to Pittsburgh for a similar assignment with the Pittsburgh Department of Health.

Since then he has been with the Jones & Laughlin Steel Corporation, and since 1958 has been with the United States Steel Corporation, for which he is now Director of Industrial Medicine.

Veterans Administration Allocates $15 Million in Accelerated Spending

The Veterans Administration has allocated $15 million in accelerated spending for the VA Department of Medicine and Surgery.

In Indiana, the Fort Wayne Hospital will receive $30,800 for drugs and other medical purposes. The Indianapolis hospital will receive $32,930 for drugs and $94,000 for dental care for Vietnam veterans.

Addresses Nurses

Dr. W. Thomas Spain, director of medical education at St. Mary's Hospital, Evansville, was the keynote speaker recently for graduation ceremonies for 37 members of the Evansville School of Practical Nursing.

Discusses School Programs

Dr. John T. Burns, Lafayette, discussed school programs in the Lafayette area at a recent meeting of the Burtsfield School PTA. The teaching of human growth and development was the subject of the panel discussion.

Attends Meeting

Dr. L. Ray Stewart, Evansville, president of the Vanderburgh County Unit of the American Red Cross, attended the Indiana Division Crusade Leadership Conference held in French Lick recently.

Study of Hospital Fires Booklet Published by NFPA

A study of hospital fires has just been published by the National Fire Protection Association. The 16-page booklet summarizes the lessons from the observation of 40 hospital fires of all types.

"Occupancy Fire Record of Hospitals" may be obtained for $1.50 from the Association at 60 Batterymarch St., Boston 02110.

TB Seminar

Drs. Glen A. Ramsdell and Ray A. Weitemier, Richmond, attended a four-day seminar recently on tuberculosis at the National Communicable Disease Center at Atlanta, Ga., given by the U.S. Public Health Service.

Dr. Terry Re-Elected

Dr. Robert H. Terry, Boonville, has been re-elected to active membership in the American Academy of General Practice.

Continued on page 827.

I love my family.
I adore this house.
My in-laws are great.
The neighbors are wonderful.



Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

The young homemaker: her underlying anxiety and tension can surface and intensify under the continuous stress of rearing a growing family. Especially when she's confined to the home and its environs so much.

You can help her over the rough spots with reassurance and counsel. Equanil can help relieve tension, ease anxiety—with little risk of serious side effects. Time and experience will probably do the rest.

Equanil®
(meprobamate)

Wyeth Laboratories
Philadelphia, Pa.

Photo professionally posed.



NEWS NOTES

Continued

Dr. Records Honored

Dr. John Records, Franklin, has been awarded the Distinguished Service Award presented annually by the Franklin Jaycees for his work on drug abuse, the hazards of smoking and for his service to the community.

Dr. Justin Elected

Dr. Renate Justin, Terre Haute, is the first president of the Planned Parenthood Association of Vigo County.

Passano Award for 1970 Goes to Dr. Paul C. Zamecnik

The $7,500 Passano Award for 1970 has been presented to Dr. Paul C. Zamecnik, Professor of Oncologic Medicine at Harvard University Medical School.

The award is for Dr. Zamecnik's research on the chemical processes in normal and tumor cells, especially concerning the synthesis of protein.

The Passano Award is sustained by annual contributions from the Williams & Wilkins Company, publishers, and Waverly Press, Inc. It was founded by the late Edward Boteler Passano, founder of the two companies. The stature of the Passano Award is testified to by the fact that six of the 30 Passano laureates have subsequently received the Nobel Prize.

Doctors' Unit Elects

Dr. John Barrow, Dale, has been elected president of the First District, Indiana Academy of General Practice. Other new officers are **Drs. C. W. Hachmeister,** vice president and **R. L. Harris,** secretary-treasurer.

Dr. Crockett Speaks

Dr. Wayne Crockett, Terre Haute, spoke recently before the ninth annual joint boards' meeting of the Association of National Health Agencies at Terre Haute. He spoke on "Local Planning for Expanded Medical Education."

Drug Abuse Speaker

Dr. Roger Newton, group director of medical research at Mead Johnson and Co., spoke recently at the opening of a series of lectures on drugs and drug abuse at the University of Evansville.

Keynote Speaker

Dr. Walter Compton, president of Miles Laboratories and chairman of the Elkhart conference, was the keynote speaker at a dinner kicking off the 1970 campaign for a new YM-YW and improvements at the Girl Scout's Camp, at Elkhart.

Indiana Pesticide Council Completes Series of Public Meetings

The Indiana Pesticide Council has completed its series of public meetings. The meetings at Valparaiso on April 7 and Vincennes on May 7 concluded the statewide hearings. Views and opinions of interested persons and organizations have been collected for guidance of the council recommendations.

Physician Elected

Dr. Fred Dierdorf, Terre Haute, has been elected president of the Terre Haute chapter of Citizens for Decent Literature, Inc.

New Centurion Club Members

Drs. William F. Fechtman, Ray D. Foster, and Sidney L. Stevens, Indianapolis, are announced as new members recently inducted into the Centurion Club. The club is a national voluntary health agency devoted to the problems of deafness and its prevention.

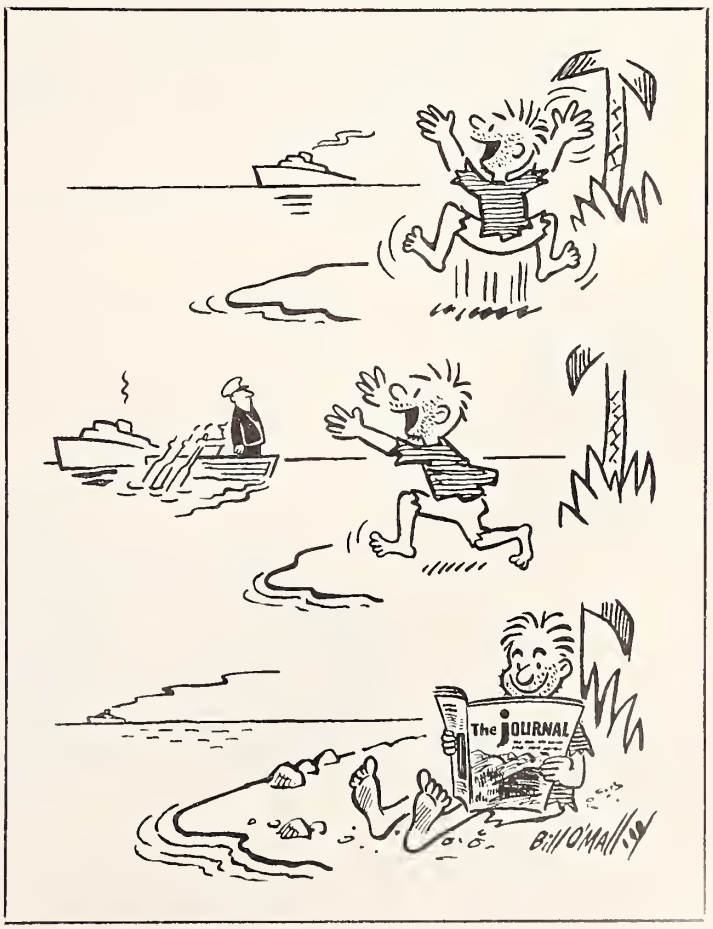
Elected to Membership

Dr. E. H. Bergendahl, Fort Wayne, was recently elected to membership in the American Society for Head and Neck Surgery at its annual meeting in Hollywood, Florida. **Drs. Thomas Johnson and Raleigh Lingeman, Indianapolis, and Dr. Charles Giffin, Fort Wayne,** are members of the society from Indiana.

Michigan Professor Wins Parke-Davis Award for 1970

The Parke-Davis Award for 1970 goes to Dr. A. Rees Midgley, professor of pathology at the University of Michigan, for his research study of human fertility.

The award, which consists of $1000 and a gold medal, is



awarded annually to a member of the American Society for Experimental Pathology "who has made the most outstanding contribution to the conquest of disease."

Dr. Tetrick Speaks

Members of the Chesterton Women's Club heard **Dr. E. Lain Tetrick, Ogden Dunes,** speak recently on how to protect your heart.

Appear on TV

The coronary care unit of the Jay County Hospital was featured recently on the "Muncie At Noon" television show. Participating in the show were **Drs. W. H. Cripe and Eugene Gillum, both of Portland.**

Dr. Swaim is Chairman

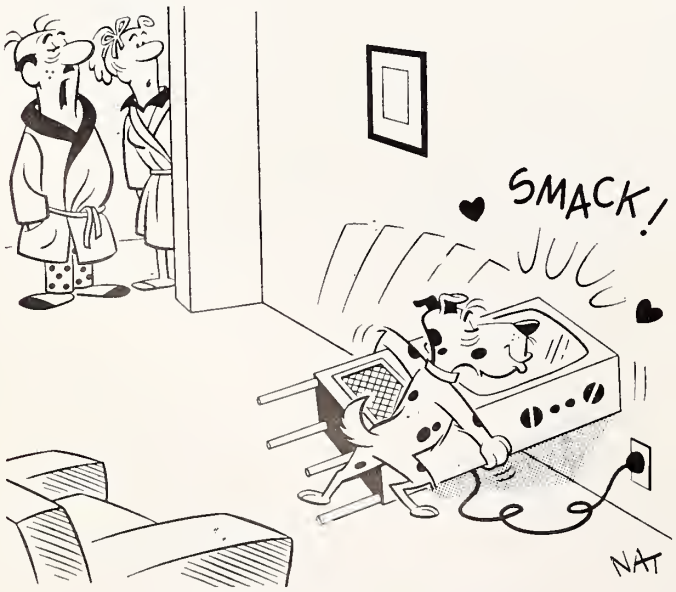
Dr. J. Franklin Swaim, Rockville, has accepted the chairmanship of the four county northern Indiana area for Indiana State University's $1.5 million University-Civic Amphitheater fund campaign. He will head the volunteer organization of citizens in Vermillion, Parke, Putnam and Owen Counties.

Addresses Commencement

Dr. A. W. Cavins, Terre Haute, gave the graduation address recently at the Vigo County School Corp. Vocational School of Practical Nursing commencement.

Dr. Nichols Honored

Dr. Anne S. Nichols, Greencastle, was honored recently by DePauw's radio station, WGRE, as the ESP (Extra Special Person) of the week. Dr. Nichols is instrumental in many community projects and devotes much of her time to the Girl Scouts of America.



It's that dog food commercial again.

Speaks on Cancer

Dr. Lowell Smith, Cassopolis, spoke on the subject of cancer at a recent meeting of the Michigan Kappa Delta chapter of Beta Sigma Phi Sorority at Elkhart. Dr. Smith outlined the different types of cancer, gave warning signs and told members about treatment currently being used against the disease.

Dr. Ogle on Program

Dr. Robert W. Ogle, Greenwood, showed films on coronary care for the Johnson County RN Club recently in the doctors' library at Johnson County Memorial Hospital, Franklin.

"Marcus Welby's" Producer Receives AAGP's Top Award

The American Academy of General Practice presented its Certificate of Meritorious Service recently to David Victor of Hollywood, executive producer of "Marcus Welby, M.D.," in recognition of the television series which is one of the nation's favorite presentations.

The underlying theme of the show, in which Robert Young plays the doctor, is that proper medical practice should be focused on the whole person.

Speak at Symposium

A symposium on trauma emergency care, held recently at St. Elizabeth Hospital in Lafayette in conjunction with Indiana University School of Medicine, was the first of its kind in the state. Speakers at the symposium included: **Drs. Charles Rutherford, Lindley Wagner, James Raymond, Jacob Sheeres and James Keplinger, all of Lafayette.** Guest speakers from the I.U. School of Medicine were **Drs. Harold King and Carl D. Martz.**

Dr. Bowen Speaks

Dr. Otis R. Bowen, Bremen, was guest speaker at the Newton County Lincoln Day Banquet at Brook recently. He was also honored by an invitation from President Nixon to attend the 18th annual Presidential Prayer Breakfast at the Washington Hilton Hotel.

Dr. Dupler is Speaker

Dr. Lee Dupler, Frankfort, discussed "TB and the General Hospital" at a recent meeting of the board of directors of the Clinton County Tuberculosis Association, at Clinton County Hospital. The speech described a new concept in treatment of tuberculosis in a general hospital.

Dr. Krueger Speaks

Dr. John E. Krueger, South Bend, was guest speaker at a recent meeting of the Women's Auxiliary to the St. Joseph County Medical Society. Dr. Krueger is medical advisor to the inhalation therapy department and explained the work of his department.

Kiwanis Speaker

Dr. Max Norris Indianapolis, spoke recently before the Crawfordsville Kiwanis Club on Scout Civic Day. Dr. Norris is president of the Central Indiana Council of Boy Scouts of America. ◄

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CLINICAL CONVENTION
Date Nov. 29-Dec. 2, 1970
Place Boston, Mass.

INDIANA ACADEMY OF GENERAL PRACTICE
Date April 20-22, 1971
Place Indianapolis Hilton

INDIANA PUBLIC HEALTH ASSOCIATION
Date April 20-22, 1971
Place Indianapolis Stouffer Inn

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA ROENTGEN SOCIETY
Date March 14, 1971
Place Holiday Inn East, Indianapolis

INDIANA PSYCHIATRIC SOCIETY
Date Second Wednesday of September, November, January, February, March and April
Place For time and place, inquire Wesley A. Kissel, M.D., 1815 N. Capitol Ave., Indianapolis 46202

INDIANA STATE ASSOCIATION OF MEDICAL ASSISTANTS
Date April 23-25, 1971
Place LaSalle Motor Inn, South Bend

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 4-6, 1971
Place French Lick Sheraton, French Lick

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 12-15, 1970
Place South Bend

INDIANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS
Date May 12-13, 1971
Place Indianapolis Stouffer Inn

THE INDIANA SOCIETY OF INTERNAL MEDICINE
Date October 14-15, 1970
Place South Bend

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY
Date Oct. 21, 1970
Place Atkinson Hotel, Indianapolis

INDIANA ASSOCIATION OF PATHOLOGISTS
Date December 5, 1970
Place Indianapolis Motor Speedway Motel, Indianapolis

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FUTURE MEETINGS, SEMINARS, COURSES

Second Annual Birth Defects Symposium Set for October 30-31

"Disorders of Glucose Metabolism in Children," the second annual Birth Defects Symposium, will be October 30-31 at the University of Florida College of Medicine, Gainesville, Florida.

Sponsored by the University's Institutional Division of Endocrinology and Metabolism and the National Foundation—March of Dimes Birth Defects Center, the symposium will feature discussions of diabetes mellitus, hypoglycemias of childhood and energy metabolism, as well as case presentations.

Registration fees will be waived for interns and residents. For additional information and schedule of fees, please write Mrs. Betty L. Howard, Division of Postgraduate Education, J. Hillis Miller Health Center, Gainesville, Florida 32601.

XI International Congress of Internal Medicine in Delhi, India

The XI International Congress of Internal Medicine is being held in Delhi under the aegis of the Association of Physicians of India from October 25-30, 1970.

Excellent scientific and social programs are being arranged. Further particulars can be obtained from the Congress Secretariat, V.P. Chest Institute, Delhi University, Dehli-7.

Congress of County Medical Societies Annual Meeting and Seminar

The Congress of County Medical Societies has announced the dates for its 1970 Annual Meeting and Seminar on Private Practice. The meetings are scheduled for November 6-7-8, 1970, at the Netherland Hilton Hotel in Cincinnati, Ohio.

The Congress of County Medical Societies was formed in 1965 as a mechanism for the exchange of information among practicing physicians and their local medical societies. Currently, 70 county societies participate as members and more than 63,000 physicians belong to the organization, making it the second largest medical organization in the country.

Any licensed physicians and all medical society personnel are invited to attend.

National Conference on Cancer Of the Colon and Rectum in 1971

The National Conference on Cancer of the Colon and Rectum will be held at Hotel del Coronado in San Diego on January 7 to 9, 1971. It is sponsored by the American Cancer Society.

The subject will be discussed by leading authorities. Epidemiology, etiology, detection, diagnosis and treatment will be covered. For copy of the program and other details write Roald N. Grant, M.D., 219 E. 42nd St., New York City 10017.

Fourth Annual Newborn Symposium November 5-6 at Louisville, Kentucky

The Department of Pediatrics, University of Louisville School of Medicine will present its Fourth Annual Newborn Symposium November 5-6.

Participants (alphabetically) will be: Drs. Marvin Cornblath, Louis Gluck, Harry H. Gordon, Charles Lowe, Grant Morrow, III, Gerard B. Odell, Leo Stern, Robert Usher, and faculty of the Department of Pediatrics, University of Louisville School of Medicine.

For further information write: Billy F. Andrews, M.D., Professor and Chairman, Department of Pediatrics, 226 East Chestnut Street, Louisville, Kentucky 40202.

Hospital Medical Staff Conference September 28-October 2

The Hospital Medical Staff Conference will be held at the YMCA Conference Center, Estes Park, Colorado, on Sept. 28 to Oct. 2, under the auspices of the University of Colorado School of Medicine.

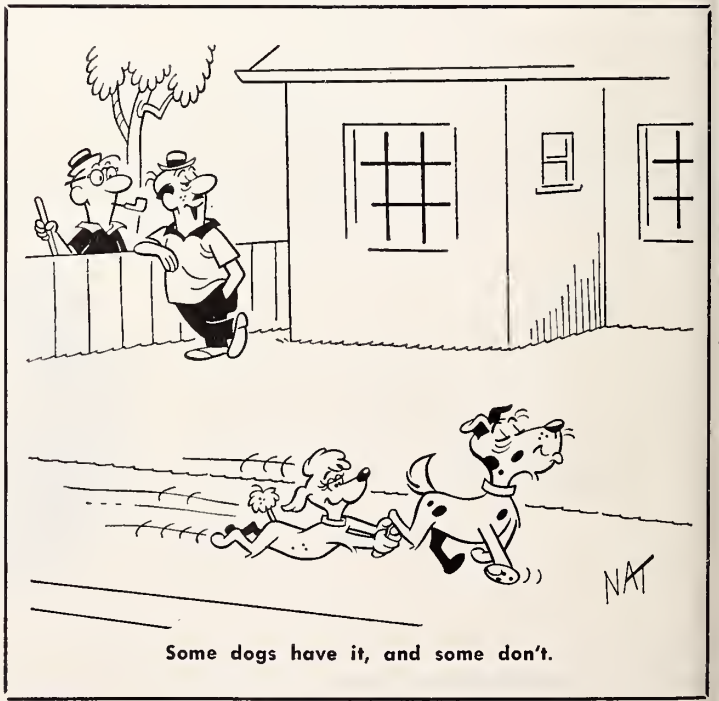
The tuition fee for the five days is $100. The material presented will be the same or similar to that presented in previous years. Repeat attendance is discouraged.

The conference is approved for 32 prescribed hours by the AAGP. Write the Office of Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

American Society of Human Genetics Meeting in Indianapolis

The American Society of Human Genetics will meet at the Indianapolis Hilton Hotel on October 11 to 14.

The Department of Medical Genetics of the Indiana University School of Medicine will host the meeting. The national society has a membership of about 1200, about half of whom are physicians. Interested members of ISMA are invited to attend.



Some dogs have it, and some don't.

American Congress of Rehabilitation Medicine Will Hold Annual Session

The American Congress of Rehabilitation Medicine will hold its annual session at the New York Hilton Hotel on August 19 to 21. For full details write the Congress at 30 N. Michigan Ave., Chicago 60602.

Second Annual Cleveland Course in Pulmonary Disease

The second annual Cleveland Course in Pulmonary Disease will be held October 14 to 16, at St. Luke's Hospital. The program will focus on respiratory impairment, clinical manifestations and treatment. Write Department of Postgraduate Medical Education, Case Western Reserve University, 2109 Adelbert Road, Cleveland 44106.

"Otolaryngology for the Family Practitioner" Course Offered in Miami

A postgraduate course on "Otolaryngology for the Family Practitioner" will be presented by the University of Miami School of Medicine on November 13 to 14 at the Sheraton Four Ambassadors Hotel in Miami. The course is accredited by the AAGP.

Write Dr. Frederic W. Pullen, II, University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami, Florida 33152.

ACEP Second Scientific Assembly Will be October 18-23 in Las Vegas

The American College of Emergency Physicians will hold its Second Scientific Assembly in Las Vegas, Nevada, October 18-23. Its focus will be on the delivery of primary care in the hospital emergency department.

For information wrrite: Executive Secretary, 120 West Saginaw, East Lansing, Michigan 48823.

Twelfth Congress of the Pan-Pacific Surgical Association

The Twelfth Congress of the Pan-Pacific Surgical Association is announced for February 26 to March 3, 1972.

Concurrent meetings will be held in eleven surgical specialties. It will meet in the Hilton Hawaiian Village Hotel in Honolulu, Write the Association at 236 Alexander Young Bldg., Honolulu 96813.

Seminar in Obstetrics and Gynecology November 19-20 in Florida

A Seminar in Obstetrics and Gynecology will be conducted on November 19 and 20, at the University of Florida College of Medicine in Gainesville.

Write the Division of Postgraduate Education, Box 758, College of Medicine, Gainesville 32601.

Postgraduate Course in Laryngology, Bronchoesophagology

The Department of Otolaryngology of the University of Illinois at the Medical Center will conduct a postgraduate course in Laryngology and Bronchoesophagology from November 9 through 20. This course is limited to 15 physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the Eye and Ear Infirmary of the University of Illinois Hospital, 1855 West Taylor Street, Chicago, and will include visits to a number of other Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures and several motion pictures.

Interested registrants will please write directly to the Department of Otolaryngology, Abraham Lincoln School of Medicine of the College of Medicine, University of Illinois at the Medical Center, Postoffice Box 6998, Chicago, Illinois 60680.

Flying Physicians to Meet in Vancouver, B.C., in August

The Flying Physicians Association will hold its 16th annual meeting, its first outside the United States, in Vancouver, British Columbia, on August 23 to 28. The Bayshore Inn will be headquarters. Between 700 and 900 persons are expected to attend.

Facilities will be ready for more than 200 aircraft. The association, which had 700 members in 1955, now has over 2200. Doctors from all over the world belong—all members must hold valid pilot certificates and must belong to a medical society which is approved by the association's directors.

Indiana Physicians to Speak at Boerhaave Postgraduate Course

Drs. Carl B. Sputh and Sydney L. Stevens, Indianapolis, will be members of specialist faculty of the Boerhaave Postgraduate Course in "Functional Corrective Surgery of the Nasal Septum and External Pyramid" which will be conducted at Leiden University in Leiden, Holland, August 30 to September 9.

The official language is English. More than thirty distinguished specialists will participate. Course membership is limited. For full information and application forms write to J. Stelling, M.D., Afd. K.N.O., Academisch Ziekenhuis, Leiden, Holland.

Annual Otolaryngologic Assembly Set for September 19-25

The Annual Otolaryngologic Assembly of 1970 will be held September 19 through 25 in the Eye and Ear Infirmary of the University of Illinois Hospital. The Department of Otolaryngology, College of Medicine, University of Illinois at the Medical Center, offers a condensed postgraduate basic and clinical program for practicing otolaryngologists under the direction of Doctor Emanuel M. Skolnik. It is designed to bring to specialists current information in medical and surgical otorhinolaryngology.

A separate, but correlated course "Conference on Radiology in Otolaryngology and Ophthalmology" will be held this year on November 27 and 28, under the guidance of Doctor Galdino E. Valvassori. For further information about the radiology conference, write to Professor Valvassori, Radiology Department, College of Medicine.

Interested otolaryngologists should direct their inquiries to the mailing address: Otolaryngology, P.O. Box 6998, Chicago, Illinois 60680. ◄

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—May, 1970

Disease	May 1970	Apr. 1970	Mar. 1970	May 1969	May 1968
Animal Bites	1477	787	516	1431	1168
Chickenpox	471	459	506	637	482
Conjunctivitis	129	153	164	199	116
Diphtheria	0	0	2	0	0
Dysentery, Unspecified	14	0	5	36	12
Gonorrhea	715	658	608	582	465
Impetigo	90	85	107	98	62
Infectious Hepatitis	80	49	69	67	54
Infectious Mononucleosis	121	71	76	118	221
Influenza	734	1244	5041	1284	444
Measles					
Rubeola	53	54	59	133	143
Rubella	351	442	399	602	203
Meningococcic Meningitis	5	2	6	5	2
Meningitis, Other	3	5	2	2	6
Mumps	337	314	369	485	701
Pertussis (whooping cough)	17	4	7	9	33
Pneumonia	482	390	479	271	166
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	844	861	1025	865	629
Syphilis					
Primary & Secondary	35	40	51	39	38
All Other Syphilis	168	108	115	118	124
Tinea Capitis	1	5	3	10	6
Tuberculosis (Active)	76	112	75	42	89

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When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenamena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

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One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information — Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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Specific therapy for night leg cramps

County, District News

First District

The First District Medical Society, meeting May 7, elected the following as new officers for 1970-71: Drs. Fred Smith, Tell City, president; Ray Burnikel, Evansville, vice president and Bernard B. Rosenblatt, secretary-treasurer. Dr. Raymond N. Newnum, Evansville, was elected alternate trustee and Dr. Willard T. Barnhart, Evansville, was elected Blue Shield Board member.

Third District

The Third District chapters of the ISMA and the Indiana Academy of General Practice held their annual meeting in April at New Albany. New officers of the Third District Medical Society are: Drs. Daniel Cannon, New Albany, president and Donald R. LaFollette, New Albany, secretary-treasurer. Dr. Eli Goodman, Charlestown, was elected trustee.

Fourth District

New officers of the Fourth District Medical Society are: Drs. Gordon Fessler, Rising Sun, president and Fred D. Houston, Lawrenceburg, secretary-treasurer. Dr. Jack Shields, Brownstown, was elected to another three-year term as alternate trustee.

Sixth District

Dr. David Wynegar, Richmond, is the new president of the Sixth District Medical Society. Other new officers elected at the May 6 meeting included: Drs. Mark Smith, New Castle, vice president and John Moenning, Greenfield, secretary-treasurer. Dr. Stephen Smith, Knightstown, was re-elected trustee and Dr. Paul M. Inlow, Shelbyville, was elected alternate trustee.

Twelfth District

Newly-elected president of the Twelfth District Medical Society is Dr. George C. Manning, Fort Wayne. Other new officers are: Drs. Franklin Bryan, Fort Wayne, vice president and William B. Hughes, Waterloo, secretary-treasurer. Dr. William R. Clark, Fort Wayne, was re-elected trustee and Dr. Kenneth Isenogle, Fort Wayne, was re-elected Blue Shield Board member.

Clinton

New president of the Clinton County Medical Society is Dr. Charles E. Bush, Kirklin. Dr. Francis E. Carrel, Frankfort, was re-elected secretary-treasurer.

Dearborn-Ohio

Gary Miller and Fritz Harbridge, of Blue Shield, spoke on "Comprehensive Health Planning" at the May 7 meeting of the Dearborn-Ohio County Medical Society.

Dubois

The Dubois County Medical Society has elected Dr. Harry L. Craig, Huntingburg, president and Dr. Donald Bomalaski, Jasper, as secretary-treasurer.

Elkhart

"The Surgical Treatment of Ischemic Heart Disease" was the topic of Dr. William C. Sheldon, of the Cleveland Clinic, when he spoke at the May 7 meeting of the Elkhart County Medical Society.

Fayette-Franklin

The Fayette-Franklin County Medical Society met May 12th to hear Dr. F. W. Deanovic, Richmond dermatologist, speak. New president of the society is Dr. Francis B. Mountain, Connersville. Dr. J. L. Steinem, Connersville, was re-elected secretary-treasurer.

Fort Wayne

Dr. Russell Roth, speaker of the AMA House of Delegates, addressed the May 5 meeting of the Fort Wayne Medical Society on the subject of the AMA's Medicredit plan. Dr. Jerry L. Stucky was installed as society president at the group's annual meeting May 19. Other officers elected are: Drs. Kenneth F. Isenogle, president-elect; Eugene E. Schmidt, secretary and Robert J. Schmoll, treasurer.

Fountain-Warren

Herbert Dixon of Blue Cross-Blue Shield discussed the economics of health care at the May 7 meeting of the Fountain-Warren County Medical Society.

Fulton

Newly-elected president of the Fulton County Medical Society is Dr. Joseph D. Richardson, Rochester. Dr. F. Richard Walton, Rochester, was re-elected secretary-treasurer.

Huntington

Dr. V. Logan Love, Fort Wayne, was guest speaker at the May 12 meeting of the Huntington County Medical Society. New officers elected at the meeting are: Drs. P. E. Doermann, Huntington, president; J.B. Bennett, Warren, vice president and Reeve B. Peare, Huntington, secretary-treasurer.

Marshall

Dr. Donald Olson, Director of Medical Education, Memorial Hospital, South Bend, discussed coronary care units at the May meeting of the Marshall County Medical Society.

Tippecanoe

Richard L. Fairchild, LL.B., and members of the Tippecanoe Pharmacy Society were guests at the May 12 meeting of the Tippecanoe County Medical Society. Mr. Fairchild spoke on "Legal Aspects of Prescription Writing and Problems Involving Drug Abuse."

Vanderburgh

The May 12 meeting of the Vanderburgh County Medical Society marked the 125th anniversary of the society, which first convened in January, 1845, as the Evansville Medical Society.

Wayne-Union

Dr. Lowell H. Steen, president of ISMA, spoke on "Panel Practice vs. Foundation Practice" at the May 5 meeting of the Wayne-Union County Medical Society. New officers, elected at the meeting, include: Drs. John F. Ling, president; George M. Johnson, president-elect; John R. Dehner, secretary and Clarence G. Clarkson, treasurer.

White

Newly-elected president of the White County Medical Society is Dr. Max L. Fields, Monticello. Dr. Kingdon Brady, Monticello, was re-elected secretary-treasurer.

Whitley

"Treatment of Chronic Complainers—Those Who Need to be Ill" was the topic chosen by Dr. Frank M. Thompson, Columbia City, when he spoke at the May 12 meeting of the Whitley County Medical Society.

Deaths

William K. Adair, M.D.

Dr. William K. Adair, 87-year-old Crothersville physician, died May 29 at his home.

A general practitioner, Dr. Adair was graduated from the University of Louisville School of Medicine in 1910. He served in the First World War and was a Senior Member of ISMA, member of the 50-Year Club and the Jackson-Jennings County Medical Society.

Raymond N. Adler, M.D.

Dr. Raymond N. Adler, a general practitioner in Evansville for 33 years, died April 3 at the age of 62.

Graduated from the I.U. School of Medicine in 1936, Dr. Adler was a member of the staffs at Deaconess, Baptist and St. Mary's hospitals, the Vanderburgh County Medical Society and the American Academy of General Practice. He served as a captain in the U.S. Army Medical Corps from 1941 to 1945 and was in Alaska for 31 months of that time.

Jasper Cain, M.D.

Dr. Jasper Cain, retired physician at Heltonville and former teacher, died May 24 at Dunn Memorial Hospital, Bedford. He was 92.

A former member of the Lawrence County Medical Society, Dr. Cain practiced in Heltonville until his retirement in 1941.

Herman H. Clay, M.D.

Dr. Herman H. Clay, former Gary physician who practiced there for 31 years, died Feb. 11 in Chicago after a brief illness.

Dr. Clay went to Gary in 1925 and practiced medicine there until he returned to Chicago in 1956. He was a former member of the Lake County Medical Society.

John K. Folck, M.D.

Dr. John K. Folck, 62, Princeton, died April 28 at his home.

Dr. Folck was a general practitioner and was graduated from the I.U. School of Medicine in 1931. He was on the staff of the Gibson General Hospital there and had served as Chief of Surgery in the South Pacific during World War II. He was a member of the Gibson County Medical Society.

Samuel B. Montgomery, M.D.

Dr. Samuel B. Montgomery, general practitioner at Cynthiana, died May 18 at his home. He was 95.

A native of Gibson County, Dr. Montgomery had practiced in Cynthiana for 68 years. He was graduated from the University of Louisville in 1898 and was a Senior Member of ISMA, member of the 50-Year Club and a member of the Posey County Medical Society.

Hubert B. Pirkle, M.D.

Dr. Hubert B. Pirkle, former clinical director and staff physician at the Indiana Hospital for Chest Diseases at Rockville, died there April 12 at the age of 73.

Graduated from the I.U. School of Medicine in 1924, Dr. Pirkle had served on the staff at the Rockville Hospital for over 44 years, retiring in 1969. He was a member of the Indiana Thoracic Society; a life member of the College of Chest Physicians; a Senior Member of ISMA and a member of the Parke-Vermillion County Medical Society.

Jesse A. Sanders, M.D.

Dr. Jesse A. Sanders, 81-year-old general practitioner at Auburn, died May 19 in DeKalb Memorial Hospital.

Dr. Sanders was graduated from Vanderbilt University School of Medicine in 1914. He began his medical practice in 1918 after serving in World War I. He opened an office in Auburn in 1924 and remodeled it into a hospital a year later. The Sanders' Hospital closed in 1968 when Dr. Sanders retired. He was a member of the DeKalb County Medical Society, a Senior Member of ISMA and member of the 50-Year-Club.

Cecil M. Sennett, M.D.

Dr. Cecil M. Sennett, retired Beatty Memorial Hospital staff member, died May 20 at Westville. He was 79.

Graduated from the I.U. School of Medicine in 1924, Dr. Sennett practiced in South Bend for 25 years and was a staff physician at Beatty Hospital for 15 years. He retired from his position there in 1968. Dr. Sennett was a Senior Member of ISMA and member of the LaPorte County Medical Socicty.

William C. Wright, M.D.

Dr. William C. Wright, 73, Fort Wayne surgeon, died May 21 at Parkview Memorial Hospital there.

A native of Clinton, Dr. Wright was graduated from the University of Michigan School of Medicine in 1924 and had resided in Fort Wayne since 1930. He had been a member of the staff of St. Joseph's Hospital and an associate on the staffs of the other Fort Wayne hospitals. He was a Senior Member of ISMA and member of the Fort Wayne Medical Society. ◄

Association News

BOARD OF TRUSTEES

February 7, 1970

The Board of Trustees of the Indiana State Medical Association convened at 9:00 a.m. in Parlor Dining Room 18 of the Palmer House, Chicago, Illinois on Saturday, February 7th, with Dr. Peter R. Petrich, the chairman, presiding.

Roll call showed the following:

District	Trustee	
1	Gilbert M. Wilhelmus, Evansville	Present
2	Joe Dukes, Dugger	Present
3	Donald M. Kerr, Bedford	Present
4	Robert M. Reid, Columbus	Absent
5	Wilbert McIntosh, Riley	Present
6	Stephen D. Smith, Knightstown	Present
7	James H. Gosman, Indianapolis	Present
7	Dwight W. Schuster, Indianapolis	Present
8	Richard G. Ingram, Montpelier	Present
9	Peter R. Petrich, Attica	Present
10	Vincent J. Santare, Munster	Present
11	Lowell J. Hillis, Logansport	Present
12	William R. Clark, Fort Wayne	Present
13	Otis R. Bowen, Bremen	Absent

District Alternate		
1	Eugene W. Austin, Evansville	Absent
2	Betty Dukes, Dugger	Present
3	E. L. Wallace, New Albany	Present
4	Jack E. Shields, Brownstown	Absent
5	C. M. Schauwecker, Greencastle	Absent
6		
7	John O. Butler, Indianapolis	Absent
7	Joseph C. Kerlin, Danville	Absent
8	Paul W. Sparks, Winchester	Absent
9	Lindley H. Wagner, Lafayette	Absent
10	Thomas C. Tyrrell, Hammond	Absent
11	James A. Harshman, Kokomo	Absent
12	Frederie L. Schoen, Fort Wayne	Absent
13	G. Beach Gattman, Elkhart	Present

Officers:

Lowell H. Steen, Hammond, president — Present

Malcolm O. Scamahorn, Pittsboro, president-elect — Present

Lester H. Hoyt, Indianapolis, treasurer — Present

Hugh K. Thatcher, Indianapolis, assistant treasurer — Present

Journal:

Frank B. Ramsey, Indianapolis, editor — Present

Executive Committee:

Donald M. Kerr, Bedford, chairman — Present

Burton E. Kintner, Elkhart, member — Present

Guests:

Mr. Richard Kilborn, president, Mutual Medical Insurance, Inc.

Mr. Charles Lauer, director, AMA Communications Division

John L. Ferry, chairman, Commission on Convention Arrangements

Franklin Bryan, chairman, Commission on Medical Education and Licensure

Tim Norbeck, AMA Field Service

Staff:

Robert J. Amick, field secretary

Howard Grindstaff, field secretary

John L. Walters, field secretary

Kenneth W. Bush, administrative assistant

James A. Waggener, executive secretary

Minutes of the meeting held January 10-11 were approved on motion of Drs. Kerr and Wilhelmus.

Reports of Officers

PRESIDENT STEEN: I want to say a few philosophical things to you this morning and share a few other items which I think may be of interest to you. The times in which we live, as you are well aware, are extremely turbulent times. We have things bombarding us from all sides—both from within and without. I don't see the mortar in our walls cracking yet but it sometimes makes me stop to wonder how much more of these reverberations we can take without shattering our armor to a certain extent.

Oftentimes people become upset when others disagree with them, although disagreement really makes the world go around. Nothing can be truly monolithic in our relationship with other professions and the public. Therefore we must not only have an attitude of tolerance towards differences of opinion but we must work toward an agreement by which we can all live peaceably together—both politically, philosophically, and sociologically.

I think you, as trustees and officers of this organization, must do whatever you can to try to weld the physicians in this state into a strong healthy organization instead of one that is fragmented along a number of lines. I think one of the potential values of the special meeting of the House of Delegates may be to permit individuals to air their grievances and may permit some individuals to learn something about which they are still relatively naive. There are many people who are quite vocal about the errors that we, as a Board, have permitted. On the other hand some of these same people have not truly bothered to learn the facts or to learn what the law says about Medicaid or Medicare and therefore oftentimes speak from a faulty premise.

Doctor Steen then discussed the forthcoming "Teen Health Happening" scheduled for April 23-24 in the Manufacturers Building in the State Fairgrounds.

Next was discussed a letter from a physician addressed to the president and members of the Board of Trustees criticizing the conditions under which Title XIX was implemented in the state of Indiana and expressing the opinion that the Board of Trustees, the Executive Committee, and officers had not carried out the mandate of the House of Delegates regarding implementation of this program.

The subject matter was discussed in considerable detail by Drs. Steen, Hillis, Ingram, Kerr, Gosman, Clark, McIntosh, Schuster, Dukes and Scamahorn. The president and chairman of the Board are to jointly respond to the writer.

The chairman then called on Mr. Kilborn, president of Mutual Medical Insurance, Inc., to discuss the subject.

MR. KILBORN: First of all Blue Shield did indicate to the federal government they were interested in participating in Medicare after consulting with the Indiana State Medical Association. If you will recall the AMA did go on record as recommending the Blue Shield Plan throughout the country become active participants in the Medicare program. Having that action behind us, we approached the Indiana State Medical Association and received similar encouragement. We did not encounter any particular problem in that stage.

The problem arose when the buy-in program for welfare recipients over 65 under Title XVIII was instituted. If you will recall at that time, the then welfare department director, Mr. Albert Kelly, advised Blue Shield that we would have to advise all physicians in the state that it would be necessary for them to take assignments. Being relatively new on the job. I wrote that letter, or actually Mr. Dixon did, and that was the start of the tremendous problem for everyone.

Several trips were made to Washington by our staff as well as some of your officers and we tried to get this welfare buying proposition on a basis with which the doctors of Indiana could live. It finally ended up being agreed that this one time agreement would be acceptable to the Indiana State Medical Association and

was so approved by the board of Blue Shield as well as the Board of the association.

At the House of Delegates meeting, I think I forget the language, but I did have occasion to review this recently, and the House of Delegates did vote a resolution that said the concept of assignment was odious to the state medical association and to the members of the association and asking that the association do everything in its power to alleviate such problems in the future. I can assure you that both Blue Shield and the Indiana State Medical Association's Board of Trustees have done everything in their power to overcome this assignment problem.

The original law passed in Indiana does not go into assignment versus non-assignment or anything like that. All the Indiana law does is strictly an enabling act. The federal act becomes the dominant law. The Indiana law just ties into the federal law which is the over-all governing influence upon the Medicare and the Medicaid programs. The federal law is where we run into the problem of assignments. The federal law also includes the 75th percentile. The law itself does not specifically do it but says that the secretary has the power to do it and the secretary put it through in the way of several proclamations which have the full force and effect of law if not disagreed to by the Congress of the United States. Here again we were aware that the assignment would be disagreeable to physicians but all Blue Shield is doing is acting as administrator for the program. We did not make the rules in any sense of the word. Both Mr. Sterrett, the welfare administrator, and I tried everything we could to obviate the necessity of any agreements in Indiana. We finally ended up with a compromise agreement that was acceptable to the Secretary of HEW but very reluctantly, which is now a one time assignment form. The physician can get out of it any time he so desires.

CHAIRMAN: The verbatim record of Resolution 69-35 which we are discussing says the following:

"Be it resolved, that the present arrangement between Blue Shield and the State Department of Welfare and the Indiana State Medical Association calls for a blanket assignment form to be signed by the physician is odious to this House of Delegates and further, that this House of Delegates urges the president, the Executive Committee, and the Council to do all in their power to remove this abrogation of freedom from this, or any other arrangement, having to do with physician payment."

DR. INGRAM: I would just like to comment I think the Board has done nothing wrong. Things have been done with which many people disagree, me included, but nothing wrong according to the resolution. I did not know exactly what it said and I think it should be quoted to the membership.

DR. SCAMAHORN: I think, if Mr. Kilborn could, it would be well for him to give to this Board the chronological data on the activities with this resolution.

DR. STEEN: I would like to highlight something but I don't want to beat you to death. You will remember at the last Board meeting I talked about the necessity for attempting to work out alternatives for the current Medicaid program. This has been assigned to the Commission on Governmental Medical Services and the Joint Board Committee. I think we are working toward the resolve of the problem but it is not a simple problem. It is not one that can be resolved by a snap of the finger. I think we have to have an environment in which we can come to some consensus of all the physicians in the state and no matter what consensus we come to, there are going to be some people who are unhappy. I am unhappy. Philosophically, I am unhappy with it. It just so happens that mechanically there is no great problem but I still resent the manner in which the thing has been done. We will work, and will keep on working until we come up with something that is at least reasonably satisfactory to the majority and that is the best we can do.

The matter was further discussed by Mr. Kilborn and Drs. McIntosh, Thatcher, Kintner and Wilhelmus.

CHAIRMAN: I would ask all of you to keep this subject in mind so that the president and the Board of Trustees can formulate a statement to answer some of the comments which have been received.

I will now introduce to you Mr. Charles Lauer, the new Director of the AMA Communications Division for a presentation of the new programs being instituted by the AMA.

Mr. Lauer then presented a pictorial presentation of the various departments and department projects within the Communications Division of the AMA.

CHAIRMAN: We will now have the report of the president-elect, Dr. Scamahorn.

DR. SCAMAHORN: The president-elect discussed the necessity of communicating with not only the members of Congress but with the members of the state legislature and the only way to change some of this legislation is by electing the proper individuals. He urged that doctors fully support their state PAC organization in the hope that sufficient funds would be received and some consideration given to PAC activity in state legislative races.

CHAIRMAN: We will now proceed with the Treasurer's Report.

Dr. Hoyt presented a report of the fund balances, investments, and the income and expenses for the month of January. He also gave a report on the financial condition of *The Journal*. The report was adopted on motion of Drs. Hoyt and Wilhelmus.

CHAIRMAN: We will now hear a report from the editor of *The Journal*, Dr. Ramsey.

DR. RAMSEY: In reviewing the financial report of *The Journal*, there is a discrepancy which I plan to discuss with the bookkeeper as I do not believe *The Journal* was operated in the red since the first of October.

There has been a little more interest in *The Journal* recently and I think probably the column we call "Lounge Talk." I am sure many of the trustees and officers think there has been a little too much pressure at the seams lately and I don't know whether this is too much or not. I think we have suffered from the fact that we did not get enough playback from the membership. I do realize that the playback we are getting in "Lounge Talk" is a little disturbing but I would like to point out that I don't publish those things purely as reading matter. Dr. Hill does not have to have a page in *The Journal* to talk to everybody. I think the purpose of publishing things like this, regardless of their value or sincerity or any other consideration, is the hope that I had —we would get some playback from some people who are of opposite minds. Then I could publish them and make this a sort of published discussion of all of our problems by our membership. I still think we should get some playback on it and that is what I am hoping for.

I would like to discuss a more pleasant subject now and that is the first dose of insulin, and about the first dose in the world, was given in an Indianapolis hospital in August of 1922. In a little over two years from now we had planned to have a special issue in August to commemorate that event. We are hoping to have the doctors and technicians who were involved in that first dose of insulin and are still alive to prepare articles for *The Journal*.

CHAIRMAN: Thank you, Dr. Ramsey.

DR. GOSMAN: Going back to Dr. Ramsey's remarks about those letters, I am

wondering if at this time the editorial comment might be included at the end of the article where specific information as we have been going over today might be an addendum.

This was further discussed by Drs. Kerr, Ramsey, Steen and Hoyt.

CHAIRMAN: Mr. Kilborn, will you now discuss the proposal you have made on the panel program?

MR. KILBORN: The use of the term "panel" is probably a misnomer and after the last meeting of my board, several of the board members requested me to come up with a better term because the panel concept is greatly misunderstood by physicians throughout the state. I would prefer calling it, and I believe it is more accurate, a Comprehensive Medical Insurance Program conducted by and through a county medical society.

Much has been, and is being said, about America's current medical system and many experts have declared that Blue Cross-Blue Shield, the hospitals, and the medical profession cannot provide sufficient, effective, and inexpensive care for the American public. The seeming experts maintain only a group practice program is the solution and they base this on the theory that a group practice is based on a maximum use of office and outpatient facilities and the optimum use of inpatient facilities. Most doctors would agree that the basic theory of maximum utilization of office and outpatient facilities does have great merit.

The physicians also seem to generally agree to peer review activity as being effective in maintaining high quality care at minimal cost. Indiana Blue Shield would like to experiment with some of these existing theories on the practice approach. Blue Shield would approve the formal structure of the county medical society's attempt to insure comprehensive medical care for its patients. The first step in the experiment would be to solicit the agreement with the county medical society. Blue Shield would then, with the assistance of the medical society, seek to develop a Comprehensive Health Program based on usual and customary fees for all physician's services.

Controls for such a program are obviously quite important and must be entirely in the hands of the county medical societies. The county society then would provide the peer review mechanisms and aid in determining of usual and customary fees. All physicians would be given an opportunity to participate in the county program and would sign a contract with the society agreeing to abide by the decision made by the society and to accept the fee allowed by the society committee as full payment for members of Blue Shield enrolled in the comprehensive program. The Blue Shield member of the comprehensive program would not be forced to receive his care from a physician in the program. The program would include insurance based on the preferred schedule and such fees would be paid for the care of patients who use non-participating physicians.

Under the Comprehensive Care Plan and the services covered thereunder, full payment would be limited to covered services rendered by participating physicians. Blue Shield members who enroll in such a program would have to be educated to the effect that county societies have complete control over hospital admission and length of stay and that office facilities and hospital outpatient facilities are to be used to the fullest extent possible in accordance with the doctor's preference.

This type of program is obviously quite new to Indiana Blue Shield and to Indiana physicians. Whether or not a program of this extent can be successful is of course a question. The success or failure of such a program is predicated upon the entire effectiveness of the physicians in the county medical societies. The program outlined above is more of a concept than a program. We feel county medical societies will need to experiment with this concept and should help in developing and designing of the program in its entirety. The financial risk involved is Blue Shield's.

Mistakes for such an experiment are not all financial in nature. However, we believe the medical profession should have a great interest in testing such an experiment. Mr. Kilborn's remarks were discussed by Drs. Thatcher, Clark, Wilhelmus, Scamahorn and Dukes. The discussion then entered the field of physician's participation in the Medicaid program and the availability of names of physicians who would accept patients under the program.

CHAIRMAN: I recognize Dr. Steen.

DR. STEEN: I move that we, as the Board of Trustees of ISMA, officially petition Mr. Sterrett to release to us the number of doctors in each county that have signed the agreement to participate in the Medicaid program and I would be willing to accept the amendment that we ask for the names too.

CHAIRMAN: Motion is seconded by Dr. Gosman. Is there additional discussion?

DR. INGRAM: I move that we amend the motion to include the names.

CHAIRMAN: Dr. Ingram moves that the names be included. Is there any further discussion?

DR. GOSMAN: I do not believe the intent is to ostracize any of our boys who have signed but we do have to try and answer questions on doctors who will accept patients under the program.

DR. DUKES: I disagree with that. I thoroughly disagree with all of this. I think you are infringing on the doctors and their privacy and some of them are signing just to take care of their minimum amount and they do not want their names out that they are doing this. If they had their names out, they would be getting all of the patients. They don't want that.

DR. GOSMAN: We don't intend publishing it in the paper.

DR. DUKES: But they are calling you up and you are going to tell the people. I don't think you have any business doing that.

DR. STEEN: I think it is imperative that we at least have the number. I stipulate that this makes a big difference and I am going to tell you why. We are going into a House of Delegates very shortly and debate with selected representatives of our membership what to do on given subjects and the Medicaid program. This subject has been introduced by resolution from the Allen County Medical Society.

Now I think we, as the Board of Trustees, need to know where the distribution of people who have signed this thing is and I would personally feel that those of us from our own particular county need to know who has signed. We are going to be asked somewhere along the line to defend physicians who are going to collect over $25,000 a year from this program. Dr. Dukes, Dr. Santare, and everyone of us around this table, I think we had better not back into a buzz saw without our eyes wide open. I think this should be looked at in an executive session of the Board as an educational process so we may be prepared with the appropriate answers when these matters come up on the floor of the House.

DR. DUKES: That was the point I was trying to make awhile ago when you talked about these Medicare claims. I think though that many of the doctors would have an invasion of privacy if their names were here. **I would like to move that the amendment be stricken.**

CHAIRMAN: We have an amendment to the motion. Now we are discussing the amendment and the motion and

we will vote on the amendment very shortly.

DR. INGRAM: I would like to point out that like it or not, when you receive tax money it should be a matter of public record, whether you are a doctor or whether you are a welfare recipient, or I don't care who it is, I want the right to know where my tax dollars go and you should too and if the doctor does not want an invasion of privacy, then he should not accept tax dollars.

CHAIRMAN: Any further discussion? **The amendment is seconded by Dr. Steen and we are now voting on the amendment to the motion and that is that names be included.**

DR. HILLIS: I ask for a roll call vote.

CHAIRMAN: The secretary will please call the roll as requested by Dr. Hillis.

DR. WILHELMUS: I have never signed, never will sign, and I am against the amendment.

DR. DUKES: I am against it.
DR. KERR: Against.
DR. REID: Not voting.
DR. McINTOSH: No.
DR. SMITH: No.
DR. GOSMAN: Yes.
DR. SCHUSTER: Yes.
DR. INGRAM: Yes.
DR. PETRICH: No.
DR. SANTARE: Yes.
DR. HILLIS: Yes.
DR. CLARK: No.
DR. GATTMAN: Yes.
DR. STEEN: Yes.
DR. SCAMAHORN: No.
DR. HOYT: No.

CHAIRMAN: The vote is 9-7 against the use of names. Therefore, the amendment is lost. We will now have the question on the motion as originally stated by Dr. Steen to request from Mr. Sterrett a county breakdown numerically of those physicians who will assign their services under the Medicaid program. Question. All in favor? Those opposed. The motion is carried.

CHAIRMAN: We now have before us a request by Mr. Kilborn as to what direction he should take regarding the letter which he has read to us relative to the Comprehensive Health Insurance program.

DR. SCHUSTER: I would move that the information in this letter be sent first to component county societies and be followed in 15 days by a letter to the general membership.

CHAIRMAN: Would you put in the mechanism of the mailing that this be mailed by Blue Shield or by the state association? If agreeable, let's let Blue Shield do it. **Motion has been seconded by Dr. Steen. Dr. Steen questioned the distribution of this letter at this time inasmuch as this would be a matter which would be discussed at the special meeting of the House of Delegates.**

DR. INGRAM: I move to table the motion.

CHAIRMAN: The motion is to table —all in favor say "aye," opposed same sign. The motion to table is carried. It was then suggested by Dr. Gosman that a copy of the letter be sent to members of the Board. This was taken by consent.

Matters Referred by the Executive Committee

CHAIRMAN: We will now move to matters referred to the Board by the Executive Committee. Dr. Kerr.

DR. KERR: The Executive Committee met last night and well into the morning for that matter. There were many matters and one of significance is a letter from Dr. Edward Tyler relative to the Himler report which says:

"Dear Jim, Thank you for sending a copy of the Himler Report and soliciting my opinion. Without any reservations at all, I completely endorse the entire report."

DR. KERR: There has been a proposal to increase the disability coverage offered by the association from a maximum of $800 to $1,000. We also held a discussion relative to the 1975 AMA Clinical Session and we recommend that we invite the AMA to hold the 1975 meeting in Indianapolis. I would suggest that Mr. Waggener report to you on the facilities which will be available at that time.

MR. WAGGENER: The convention Center is scheduled to open in 1972 and will have 193,000 sq. ft. of floor space without any obstructions; 29 meeting rooms plus restaurants and many other facilities. The new Hilton Hotel is partially opened, as of today. The Marriott Hotel chain has announced plans to construct a 750 room motel on Washington Street, west of the convention center and is scheduled for operation no later than 1974. It was also reported that the Moody Bible Institute of Texas will build for leasing a new hotel on the site of the former Claypool Hotel and it will be named the Moody Hotel. This is also scheduled for completion by 1974. Therefore, it appears there will be sufficient space, meeting requirements and Class A hotel rooms, to care for an AMA clinical meeting.

DR. GOSMAN: I move that we issue an invitation through the Board of Trustees to the AMA to hold their 1975 Clinical Session in Indianapolis. The motion was seconded by Dr. Dukes and Dr. Smith, put to vote and carried.

CHAIRMAN: I will now call on Dr. Clark for an item of special business concerning the two resolutions which he has distributed to each of you and which he has been instructed to present to the Board.

DR. CLARK: I am sorry I did not get these to you earlier but I think we should take the two resolutions and I will take the first one and read the resolve:

"WHEREAS, The government and prepaid insurance mechanisms provide a usual and customary and reasonable payment for medical services in many programs, and,

WHEREAS, Through an edict of bureaucratic officialdom, payment has been restricted to a 75th percentile in Medicaid cases, and,

WHEREAS, No group negotiating mechanisms are presently available in the state of Indiana,

THEREFORE, BE IT RESOLVED, That the Board of Trustees of the Indiana State Medical Association appoint an appropriate commission or body to study this problem and submit to the next annual meeting making recommendation for the formulation of a suitable group to negotiate payments in the future."

The second resolution reads:

"WHEREAS, A large percentage of payments for medical services are now being provided by third party mechanisms, prepaid medical insurance and governmental programs, and,

WHEREAS, There is considerable discussion between physicians and these payment mechanisms regarding establishment of fees, and,

WHEREAS, Many physicians are now using California Relative Value Studies in basing their fee structures,

NOW THEREFORE BE IT RESOLVED, That the Board of Trustees of the Indiana State Medical Association instruct the appropriate commission or commissions to make a study of the applicability of the California Relative Value program or similar type relative value plan in the state of Indiana and report the results of the study, with recommendations, at the next annual meeting of the Indiana State Medical Association in October 1970, for action by the House of Delegates."

We have had several meetings on this and I think Dr. Steen talked about this and has assigned it to one of the commissions. I thought maybe an Ad Hoc Committee with the Board of Trustees could work out something with the Commission on Legislation and maybe come before the legislative body when they meet again to see if something could be done to revoke the law or at least to adjust or change it. **I want to say that this is something you do not have to pass on today but I think we should have some discussion so I would like to move to get the discussion started that these resolutions be adopted by the Board of Trustees and see what can be done about them.**

CHAIRMAN: There is a motion by Dr. Clark and seconded by Dr. Gosman that these two resolutions be accepted by the Board of Trustees and that they be forwarded to the House of Delegates. The motion was discussed by Drs. Wilhelmus, Scamahorn, Gosman, Ingram, Hillis and Kintner.

DR. STEEN: I want to call the Board's attention that the resolution said "Be it resolved that the Board of Trustees of ISMA appoint an appropriate commission." As I said before, this has already been referred, the whole subject, to the Commission on Governmental Medical Services, who is working in conjunction with the Board committee.

CHAIRMAN: Are we discussing Resolution 1 or Resolution 2?

DR. STEEN: Let's call it #2. This resolution in effect calls for a study to be made and I would think that the appropriate bodies to make such a study would be the Commission on Medical Economics and Insurance, however, I would caution the Board against hastily passing a resolution that would give any indication that we, in essence, give approval as a state body to a matter of relative value schedules, since it is the official position of the state medical association established by the House, that we are opposed to fee schedules or relative value schedules. With all due respect to my own county, Vanderburgh and several other counties who use them, it is our permission to do so, but it is the official policy of the state association that we do not approve them.

DR. SCAMAHORN: We have before the floor a motion, do we not? We have a motion to pass a resolution.

DR. INGRAM: I think both of these involve major policy decisions which really are the business of the House of Delegates. Would it be proper, I am not talking for or against them, understand, I think they should be in the right body and would it be proper here to amend this motion to refer this to the next regular meeting of the House of Delegates?

CHAIRMAN: Any further discussion?

DR. STEEN: The Board of Trustees has in the past received resolutions from county societies asking for Board action. The Board of Trustees has a motion that the Board of Trustees introduce it as a motion; and the Board votes to forward it to the House of Delegates for consideration is certainly appropriate.

DR. KERR: I move that we amend and refer Resolution No. 2 to the Commission on Medical Economics and Insurance. The motion was seconded by Dr. Scamahorn and Dr. McIntosh and carried.

CHAIRMAN: We will now vote on the motion as amended—which was put to vote and carried.

CHAIRMAN: Dr. Kerr, will you now continue.

DR. KERR then read a letter from the Vigo County Medical Society. I do not know of any action that needs to be taken on this letter but I think there are some points in the letter which might be considered when this discussion comes up in the House and perhaps from this something might be usable for action. There was then general discussion and comments for informing the general membership of some of these comments prior to the meeting of the House of Delegates so they would have a full understanding of some of the problems.

Reports from Commissions and Committees

CHAIRMAN: We will proceed with reports of the Board committees and I will report as chairman of the Liaison Committee on Medical Education. I have discussed with Dean Irwin and Steve Beering some of the potential plans for the fall meeting between the association and the faculty which I am encouraging to take place in Indianapolis. In addition to the faculty and members of the association, this would again include a representative group of students. It is a worthwhile endeavor and as far as constructive ideas, the meeting proved very successful last year. I hope this will be held sometime in the fall and will be announced in ample time so that all can attend who would like to do so.

DR. SCHUSTER: We would like to bring our views to the state in regards to some policy statements from the state on the Governor's Commission on Medical Education. When this was brought up in our society by one of our trustees and the fact that Mr. SerVaas and his committee are taking some pretty far-reaching steps, and that there has been little direct communication with any branch of medicine, the question arose as to whether or not the state association had taken any official stand upon the entire matter.

The Marion County Medical Society has adopted a resolution and sent a letter to the Governor asking pertinent questions about this entire program and indicating a desire to be informed and to be able to participate. The letter was toned down a little from its original intent and included a suggestion that perhaps Mr. SerVaas come to our society to advise the membership as to what actually was taking place. It appeared to me that perhaps the state association could likewise take some official stand in terms of their official relationship to the Governor's Commission on Medical Education, because of the tremendous importance of the official action which apparently is forthcoming. We understand that this is to be implemented in the Indiana plan in September of this year. **In order to put it on the table for more discussion, I move that the Board of Trustees of ISMA make some official statement as to their relationship and their policy in terms of the Governor's Commission on Medical Education.**

CHAIRMAN: The motion is made by Doctor Schuster that the Board of Trustees make some statement as to their relationship or their policy concerning the Governor's Commission on Medical Education. **Motion seconded by Doctor Gosman. Motion was discussed by Drs. Schuster, Kerr, Steen and others.**

DR. SCHUSTER: Mr. Chairman, I would like to modify my motion with the consent of the second, and state not a policy but to seek information about the program.

CHAIRMAN: We will accept that as an editorial change, which will then make the motion read, "that the Board of Trustees seek some information as to their relationship concerning the Governor's Commission on Medical Education." The second, Doctor Gosman, has accepted the change. If there is no further discussion, we will now vote on the motion. All in favor say

"aye"—opposed—same sign. The motion is carried.

CHAIRMAN: I now call on Doctor Santare, Chairman of the Board Liaison Committee with Blue Cross.

DR. SANTARE: At our last meeting, a special committee, consisting of myself and Doctor Dukes, was appointed to review the Blue Cross-Blue Shield rates of the state medical society's program. We have checked into the proposed increased benefits, which amount to about $40 a quarter and the rate increase amounts to about $40 a quarter. The increased rate was up to $150 a quarter, which would bring the total rate up from about $360 to $560 a year. We have the figures on this and I am afraid it looks rather blue. The income from fees in 1969 in Blue Cross was $394,000 and Blue Shield was approximately $129,000. They paid out $443,000 from Blue Cross and $125,000 from Blue Shield. The claim reserve current for Blue Cross should be $67,000 and for Blue Shield $30,000. The claim reserve for the previous year was $55,000 for Blue Cross and $20,000 for Blue Shield.

You subtract the difference in claim reserves and add what was paid out in incurred claims and for Blue Cross it comes out $455,000 and Blue Shield $136,000. The operating expenses for Blue Cross were $22,000 and for Blue Shield approximately $6,000. This means that Blue Cross is in the hole $82,000 and Blue Shield some $13,000. The rate benefits that would go up would be approximately $40 per frame and would be about another $140,000 so you are talking about $130,000 having to be raised by an increase in fees.

I would suggest that we tell our membership to change to another plan, such as major medical.

CHAIRMAN: Doctor Santare has moved acceptance of his report. Seconded by Doctor Kerr. All in favor? Motion was put to a vote and was carried.

CHAIRMAN: I recognize Doctor Kerr.

DR. KERR: I would like to bring to the attention of our liaison men the question of coverage of patients in extended care and nursing home facilities. **Further, I would move that the Board of Trustees ask our Blue Cross Liaison Committee to at least investigate the utilization of the review mechanisms of Blue Cross when it comes to Medicare and Medicaid.**

DR. HOYT: I would like to second the motion and would also like to comment. I would be in favor of this motion; however, I think the fundamental defect is again the law and in the regulations and not in the care.

CHAIRMAN: We have a motion that Dr. Santare's committee make an investigation. All in favor say "aye." Motion is put to a vote and carried.

(The Board then adjourned for lunch).

CHAIRMAN: I now recognize Dr. Wilhelmus, chairman of the Board Committee on Economics and Fiscal Matters.

DR. WILHELMUS: My committee has no report today except I would state that I am working along with some of the officers of the new Section on College Health needs on development of a College Health Record Form, which could be used by all the schools of our state. It will be awhile, however, before anything definitive can be developed.

CHAIRMAN: Thank you, Doctor Wilhelmus. We will now receive a report from Doctor Ingram, chairman of the Joint Board Committee on Emergency Medical Services.

DR. INGRAM: I really have nothing to report.

CHAIRMAN: We will now hear from Dr. Clark, chairman of the Joint Board Committee for Orientation of New Members.

DR. CLARK: At the last meeting of the Board of Trustees in Indianapolis, I spent an hour and a half talking to several members concerning the orientation program. The committee came up with several recommendations for discussion such as:

1. Continue as in the past with the meeting along with the regular state meeting.
2. Set up a meeting along with the combined state and county officers' meeting.
3. Set up a meeting along with the various district meetings and making it mandatory that all new state members attend same. (This I think is a good one).
4. Encourage each county society to have their own Orientation Committee as we have in Fort Wayne.
5. Have a preceptor system set up under control of county officers.
6. Specific meetings of each district with no other business than that of orientation, using the district trustee as moderator and guest speakers who are knowledgeable about what the ISMA is doing for them and what they can do for their own society.
7. He presented a seventh alternative that the orientation program should be conducted by the field men of the ISMA for the districts which they serve. He also quoted Dr. Steen, president of the ISMA, as saying that a new resolution should be prepared to present to the House of Delegates to abolish the whole program.

We are planning another meeting on April 12, and we have asked Dr. Grosz and Dr. Ochsner to contact the Dean of Indiana University School of Medicine to investigate the possibility of conducting the Orientation Program at the medical school. These gentlemen will make a report of their contact at our next meeting. **I move that this report be accepted.**

CHAIRMAN: The motion was made by Dr. Clark, seconded by Dr. Wilhelmus, that the report be accepted. All in favor say, "aye." Motion is carried.

DR. CLARK: I have now a resolution submitted by the president, which reads as follows:

"WHEREAS, the Board of Trustees has been charged with implementing an orientation program for new members, and,

WHEREAS, the Board has worked diligently to accomplish this mandate of the House of Delegates, and,

WHEREAS, the attendance of these meetings has been less than five percent of the new members and since no punitive action has been provided to force compliance with the resolution passed by the House of Delegates in 1967,

NOW, THEREFORE, BE IT RESOLVED, that this House rescind its previous action thereby abolishing the orientation program but strongly urge that all county societies establish an orientation program suited to their individual needs."

CHAIRMAN: It has been moved and seconded by Dr. Clark that the Resolution be adopted and referred to the Commission on Constitution and Bylaws. Motion carried.

CHAIRMAN: I will now call on Dr. Frank Bryan, chairman of the Commission on Medical Education and Licensure.

DR. BRYAN: I would like to report on several things. First is that of faculty appointments at the Indiana University Medical School and the second has to do with family practice.

First of all, another personal opinion —one of the finest things to happen at the school of medicine is the appointment of Dr. Beering. Dr. Beering is working with the Indiana program of medical education and has done some very fine things. He has arranged for an academic appointment to the university for the members of the Indiana programs throughout the state. He reported at our last meeting of the commission that he has just received 18 appointments for members of the Indi-

ana programs throughout the state. I think this is a good step in the right direction to at least combine the community hospital programs with the university.

In the family practice programs there are a number of physicians who have been preceptors for several years. Dr. Ringer, who is a member of the Commission on Medical Education and Licensure, has been working for recognition of preceptors who serve the university. Under consideration are certificates of recognition—and in addition to that, Dr. Ringer has approached the Dean's Office about faculty appointments. These appointments are pending formation of a new department at the university and when that department is developed, the preceptor will be considered for either a faculty or academic appointment.

I think the primary reason I was invited to speak before the Board of Trustees was that at the last meeting of the commission, a couple of motions were passed to be forwarded to the Board for consideration and action. These had to do with foreign medical graduates. Now, the chair advised the commission that foreign medical graduates were controlled by Indiana law; however, there were some motions proposed for your consideration and recommendation which I would like to discuss.

I think the background on these had to do with the fact that, primarily, Lake County has had a very serious problem of manpower shortage and they have had a number of foreign medical graduates who are competent, well-qualified and certified, who have not been able to stay in the area because of the laws in Indiana. The result of this problem is that people who are qualified and who could offer a great deal of assistance to the community have been forced to leave. I am told that there are seven qualified people who did not stay in the Lake County area because of the licensure laws of this state. The problem has been that in order to be licensed in Indiana by reciprocity there is a requirement that a doctor must have two years of resident practice medicine in the state of his licensure, and there have been a number of Board certified people who are foreign graduates who like it in Indiana and who have come to the area only to leave, because they could not qualify for the residency requirement. It was the commission's wish that the motion presented by the commission be considered by the Board of Trustees and that they assist in implementing some changes.

I will read, if you don't mind, the motion as related to our medical graduate program. Dr. Wilson is also, I think, the executive of the tuberculosis clinic and they have needed medical assistance in this group and according to our law there are foreign graduates who cannot come in there and work under supervision. Well, this led to his discussion at our last commission meeting and to the presentation of two motions. Again now I advised the commission that these were the laws of the state of Indiana and would require legislative action. It was the commission's wish in these motions that the Board of Trustees consider this and help implement some changes. I will read, if you don't mind, the minutes as related to our medical graduate problem. "Dr. Wilson commented at length on the critical situation which exists in Indiana with regards to the requirement which restricts the use of foreign medical graduates in (1) the institutional practice of medicine, and although it is not included in the minutes, the second portion had to do with the difference of qualified foreign medical graduates of private practice. Dr. Alcorn, at the Board of Medical Registration and Examination, had been invited to attend this meeting but could not appear so it was felt that the Medical Board should be approached on this problem. The Medical Board of Registration and Examination met two days after the meeting.

The motion then was (1) foreign graduates be licensed in the state of Indiana on the same criteria as used for graduates of American medical schools. This motion was seconded by Dr. Egger, put to vote and carried. This particular motion has to do with the three-year residency requirement for foreign medical graduates in the state of licensure. According to the Indiana state law before a foreign medical graduate can receive licensure by reciprocity endorsement, he must practice medicine in the state in which he was licensed for three years. The thing that brought this about was there were several well-qualified Board certified people who had come from the Lake County area to practice and could not stay because they had not qualified by virtue of the three-year residency in the state of licensure. They have come directly from the State Board to Indiana and wished to work; one was a Board-certified internist, sub-special in hematology and the other was a pediatrician; these people could not stay in Indiana because they had not lived and practiced in the state in which they were licensed for three years.

It was the consensus of the committee that the requirement concerning Board certified people who have completed their internship and residency training and are Board certified that they should be reciproeated to the state of Indiana without the three year residency requirement.

The matter was further discussed by several.

CHAIRMAN: I recognize Dr. Ingram.

DR. INGRAM: I move that we do not support the motion of the Commission on Medical Education and Licensure. Motion was seconded by Dr. Wilhelmus, motion was carried.

DR. BRYAN: The second motion of the commission had to do with the fact that the state of Indiana grant a five year temporary license permit for physicians participating in institutional practice. Now this has to do with the use of foreign medical graduates in facilities pending their graduate program and their licensure or their temporary permits. I think the only purpose for which this was brought up is again there are clinics like the T.B. units that needed help and it looks to me like places for service and in which there were foreign medical graduates who were available but not licensed —they were not qualified by their training to accept temporary educational permits and they wanted somebody to be able to serve in their hospitals under the supervision of regularly licensed physicians.

It was discussed by Drs. Schuster, Hillis, Kerr, McIntosh, Scamahorn and Ingram.

CHAIRMAN: We have a motion to not support this. It has been seconded. Is there any further discussion? All in favor, say "aye." The motion not to support was put to a vote and carried.

DR. KERR: I would like to move that these be referred back to the commission for re-definition and for a little more explanation as to why they want these things accomplished. Motion seconded by Dr. Gosman, put to a vote and carried.

DR. CHAIRMAN: Dr. Bryan, will you continue?

DR. BRYAN: As a member of the Governor's Commission on Education, I have had a deep concern from the very beginning that the Governor's Commission was politically motivated and I have been concerned about the way the course of the activities have gone and I have been concerned about the publicity. I am speaking as a personal individual now and not as a member of the commission. I was a little surprised that I was appointed to the commission, but I was glad that I was appointed to represent my particular area. I looked over the list of communities that were being considered and they seemed to correspond quite favorably with recent legislation for the establishment of a new medical school with the exception of Fort Wayne. Fort Wayne did not submit

any legislation and Fort Wayne told us they would strongly support the Indiana University's plan and program of medical education—not that they didn't want to see a medical school in the Fort Wayne area but they felt that the way to go was to support the Indiana program, of which I am a part.

At the beginning I had a number of concerns and prejudices about what was happening at the meeting. I had also heard about the qualifications of the chairman. Prior to the first meeting, we had seen much publicity about what the commission was going to do, and as a member of the commission, I knew nothing about what the commission was going to do. That added to my prejudice.

The first meeting was scheduled to set up committees to work on the various aspects of medical education. Primarily, the first problem had to do with a new medical school or a three-year medical school. The chairman has appointed some excellent, well-informed, hard-working people that were knowledgeable in general about what they were working with, as consultants with this commission.

For example, Dr. Jack Hall has worked closely with the basic science department of the school. The Dean's office has appointed Dr. Beering, who is working very closely with him and I might tell you a little bit more about Steve Beering. Steve came to Indiana late in the summer and has gotten the grasp of the Indiana program of medical education quicker than I expected of anyone. This man went out and visited areas he had never seen; he has learned what is going on.

The department heads, such as Dr. Warren Andrew, Biochemistry, Department of Pathology, and heads of various other departments have appointments as consultants and they have spent many, many hours with Mr. SerVass working out a plan. Initially, the plan was to have a two-year medical school. The original concept was to build at least seven two-year schools in the state of Indiana and they talked about a vague amount of money. They spent an hour telling us about their budget and never told us how much money they had, and they really have never come up with a dollar figure that they have presently in the legislative fund for the medical school or medical educational program. Mr. SerVaas has made it clear that this is not a study commission but an action commission and we will have by September, 1970, x-number of new medical students in the state of Indiana. I think he proposed something like 80 new students. The plan has changed from the original meeting concept of two-year medical schools, which is pretty well outdated, to a plan of medical education programs over the state.

The commission has had two meetings —the second was a long one and considered by the chairman to be a meeting in which the resolution could be approved by the commission in order to implement some sort of a program to be in effect by September, 1970. September 7 is a key point inasmuch as at the present time the state legislature does not need to authorize any program. The commission must go to the Legislature and say, "We have a program in operation now and it is providing so many more new students in so many new areas." At that point the Legislature can better see what the new educational program can offer and will be in a better position to authorize funds for a transfer program. The commission recommended the following: A definite budget be established for setting up these seven centers. The second recommendation was that the commission establish one center so that the commission would know what it costs to operate such a center as the model in the basic program. The freshman year would be a pre-clinical basic science program and it was felt that Muncie might be the best location for a pilot program.

The third recommendation of the commission was to include a budgetary requirement to expand the facilities of Indiana University to be able to accept new students, students who would be required to take their sophomore and junior years on campus. This was all the commission did at its last meeting. I might tell you at this meeting, the chairman soon learned he did not have a rubber-stamp commission and criticism was offered by several members concerning the commission being presented with a plan without an alternative and without any opportunity for the commission to propose a factual plan of its own.

DR. HOYT: Would you review the three points again please?

DR. BRYAN: The three points that were agreed upon were these:

(1.) That the commission be authorized, that is the chairman of the commission and his consultants be authorized to prepare a budget for seven centers per clinical year, that's the senior clinical year of the elected programs;

(2.) That a budget be prepared for a model basic science program at one center. It was to be set up as a model to be utilized in other studies;

(3.) Had to do with budgeting the Indiana University Medical Center facility expansion to take care of the increased number of students that it would have.

This was then discussed by Drs. Bryan, Gosman, Hillis, Dukes and Kerr.

CHAIRMAN: Thank you very much, Dr. Bryan. It was a pleasure to have you speak to us. We will take this information for information and Dr. Gosman and his group will continue to work with the group on medical education. We now recognize Dr. Ferry, chairman of the Commission on Convention Arrangements.

DR. FERRY: The commission met on January 14 and at the last meeting, in addition to other members, we had present Dr. Scamahorn and the heads of various sections of the association. There was considerable comment about previous meetings and other state meetings from our guests—most of which was rather critical. The commission, I might say, was not upset—we didn't think much of the meeting either from the standpoint of what we were able to put on and the crowd that we were able to develop.

Accordingly, we have laid out a schedule for this meeting in accordance with your wishes so that the meeting is confined to a three day period. We have attempted not to schedule any two things at the same time. The first scientific meeting will be on Tuesday evening, which will be in the nature of a "Fireside Conference." We have tried hard to choose a subject which will appeal to both physicians and to their wives and hope to enlist the cooperation of the auxiliary in wanting to attend this and to publicize this program. The probable subject will be "Care and Feeding of Adolescents" or something on this order that can bring in the emotional problems of adolescents and drug problems and the like that present day teenagers face without calling it something in mental health.

On Wednesday, the Sections on Medicine, Surgery, Pediatrics, and OB-GYN have agreed to provide one speaker for each section so that there will be four speakers on Wednesday morning dealing with subjects of general interest. These same speakers would be utilized at the section luncheons Wednesday noon, if the section so wishes. Instead of convening in an auditorium, we intend to divide them into four small groups so that people can have a kind of "meet-the-professor" arrangement and talk in small groups to these four speakers. We are planning a Gaslight Party or something of this sort for Wednesday evening.

On Thursday morning instead of having formal meetings we are attempting to arrange a series of things in which active participation by the members will be the foremost part of it; such as a pulmonary

function test—an exhibit on cardiopulmonary resuscitation—a shocking machine so that doctors and their wives can actually manipulate the model and become acquainted with this sort of thing. We have about six subjects which will run simultaneously on Thursday morning, and then the meeting will adjourn, ending with the President's Luncheon. I am not able at this time to put the names in the slots but this is the outline. I might add that the committee has been very active.

CHAIRMAN: Thank you very much, Dr. Ferry. I think, by consent, the Board endorses the program that you and your group have come up with thus far.

Economic and Fiscal Matters

CHAIRMAN: There were several commission reports that were mailed to you and I trust that you have had an opportunity to peruse them. We will now move to economic and fiscal matters. At this time we will run through the roster of trustees and if any have a matter of business to bring up, we will do so at this time.

DR. WILHELMUS: Our First District meeting will have to be changed to May 7th in Evansville to be held at the Evansville Country Club, starting at 5:30 or 6:00 p.m.

DR. DUKES: No comment from the Second District.

DR. KERR: The Third District meeting was scheduled for April 1 and it has now been changed to April 8, at which time the trustee will be unable to be there unless we can change the date again.

DR. McINTOSH: Fifth District. I will wait until a little later.

DR. SMITH: Sixth District. No new information from the Sixth District.

DR. GOSMAN: The Seventh District meeting is not changed. I have two matters to bring before the Board. The Board of Directors of Marion County Medical Society at a meeting February 3, 1970, voted to recommend that Dr. John E. Owen be given a classification as an inactive member and that his dues for 1970 be waived. Dr. Owen is no longer in active practice and will reach his 70th birthday this year. We also voted to grant reclassification as an inactive member to Dr. Marilyn R. Caldwell for the year 1970. She is not engaged in the practice of medicine. The third request was to grant inactive membership and waive the dues of Dr. Joel Eastman. Dr. Eastman has been forced to retire completely because of illness. I move that these dues be remitted.

DR. McINTOSH: Second the motion.

CHAIRMAN: Motion put to a vote and carried.

CHAIRMAN: Eighth District, Doctor Ingram?

DR. INGRAM: I have two things—the district meeting will be held on June 3rd at the Muncie County Club. The second matter is a request for remission of dues of Dr. M.J. Moss of Muncie due to illness, which has forced him to completely retire from practice. I so move. Motion seconded by Dr. Kerr, put to a vote and carried.

CHAIRMAN: Ninth District, Dr. Petrich?

DR. PETRICH: No report.

CHAIRMAN: Tenth District, Dr. Santare?

DR. SANTARE: The Tenth District has not set up their meeting as yet. It has been rather difficult to make contact with Porter and Jasper Counties concerning getting together. I might also announce that Lake County has now decided to hold monthly meetings for the next six months for discussion of many new developments such as peer review, Blue Shield, Medicaid, etc.

CHAIRMAN: Eleventh District, Dr. Hillis?

DR. HILLIS: I have two things. I would like to submit to the president that Doctor Richard Glendening be added to the Commission on Medical Economics and Insurance and that the name of Dr. George Teaboldt of Logansport State Hospital be added to the membership of the Commission on Voluntary Health Agencies.

CHAIRMAN: I am sure the president will consider your recommendations.

CHAIRMAN: Twelfth District, Dr. Clark?

DR. CLARK: I move that the dues of Dr. C. W. Dahling, of New Haven, be remitted because he has retired from active practice. Motion seconded by Dr. Kerr, put to vote and carried.

CHAIRMAN: Thirteenth District, Dr. Gattman?

DR. GATTMAN: No report.

New Business

CHAIRMAN: We will now move to new business. I recognize Dr. McIntosh.

DR. McINTOSH: It has been surprising to learn that some of the doctors don't know what a trustee is or who he is and I think it might be a good thing to periodically move the Board of Trustees' meetings throughout the various parts of the state so that our membership might become acquainted with the trustees and the operation of the Board. I would like to invite the Board of Trustees to meet in Terre Haute.

CHAIRMAN: **Do you make that an official invitation for an open-end date?**

DR. McINTOSH: **Yes, I so move. Motion seconded by Drs. Gosman and Dukes, put to a vote and carried.**

CHAIRMAN: I think the idea is a very good one. The Board of Trustees needs to be familiar with the rest of the membership.

CHAIRMAN: Any other new business?

DR. McINTOSH: **I would like to make a motion that we submit the question of executive secretaries for the various medical districts throughout the state to a proper commission —such as Future Planning Committee. Motion was seconded by many and carried.**

CHAIRMAN: We will now discuss the proposed meeting of the Board of Trustees for April 10, 11, and 12 in Florida. The matter was discussed by several and **upon motion of Dr. Ingram and seconded by Dr. Kerr, it was moved the Board follow, generally, the outline of the letter from the chairman concerning this meeting.**

DR. WILHELMUS: I have a question "Who is invited to go—the Board of Trustees and the Executive Committee?"

CHAIRMAN: Correct.

DR. WILHELMUS: How about the alternate trustees?

CHAIRMAN: I pointed out in my letter they are welcome to go if they so desire. The possibility of chartering a plane was now discussed. Much pro and con on this subject, and the secretary is to investigate the possibility.

CHAIRMAN: I urge each of you to get the word to the state office as soon as possible in order that Jim can make definite arrangements for this meeting.

CHAIRMAN: We have a called meeting of the House of Delegates on Sunday, March 15. This meeting is going to take place at the new Hilton. I am suggesting that we have a meeting of the Board on Saturday, March 14, prior to the meeting of the House. This meeting and the April meeting exclude by nature of geography the AMA delegation and I would also like to have more commission chairmen report to the Board as was the policy outlined at the beginning of the year.

I would entertain a motion that we have the next meeting on Saturday, March 14, prior to the meeting of the House of Delegates. I will tentatively set it at 1:00 p.m. If there is any change you will be notified.

There being no further business, the committee moved into executive session and immediately adjourned.

BOARD OF TRUSTEES

March 14, 1970

The Board of Trustees of the Indiana State Medical Association convened in the headquarters building at 10:00 a.m. Saturday, March 14, 1970 with Dr. Peter R. Petrich, chairman, presiding.

Roll call showed the following:

District	Trustee	
1	Gilbert M. Wilhelmus, Evansville	Absent
2	Joe Dukes, Dugger	Present
3	Donald M. Kerr, Bedford	Absent
4	Robert M. Reid, Columbus	Present
5	Wilbert McIntosh, Riley	Present
6	Stephen D. Smith, Knightstown	Present
7	James H. Gosman, Indianapolis	Present
7	Dwight W. Schuster, Indianapolis	Present
8	Richard G. Ingram, Montpelier	Present
9	Peter R. Petrich, Attica	Present
10	Vincent J. Santare, Munster	Present
11	Lowell J. Hillis, Logansport	Present
12	William R. Clark, Ft. Wayne	Present
13	Otis R. Bowen, Bremen	Absent

District	Alternate Trustee	
1	Eugene W. Austin, Evansville	Present
2	Betty Dukes, Dugger	Absent
3	Elmer L. Wallace, New Albany	Absent
4	Jack E. Shields, Brownstown	Present
5	C. M. Schauwecker, Greencastle	Absent
6		
7	John O. Butler, Indianapolis	Present
7	Joseph C. Kerlin, Danville	Present
8	Paul W. Sparks, Winchester	Absent
9	Lindley H. Wagner, Lafayette	Absent
10	Thomas C. Tyrrell, Hammond	Present
11	James A. Harshman, Kokomo	Present
12	Frederic L. Schoen, Ft. Wayne	Present
13	G. Beach Gattman, Elkhart	Present

Officers:

Lowell H. Steen, president, Hammond — Present
Malcolm O. Scamahorn, president-elect, Pittsboro — Present
Lester H. Hoyt, treasurer, Indianapolis — Present
Hugh K. Thatcher, assistant-treasurer, Indianapolis — Present

Journal:

Frank B. Ramsey, editor, Indianapolis — Present

Executive Committee:

Donald M. Kerr, chairman, Bedford — Absent
Burton E. Kintner, member, Elkhart — Present

Delegates and Alternate Delegates to AMA:

Don E. Wood, Indianapolis	Present
Eugene F. Senseny, Ft. Wayne	Present
Frank H. Green, Rushville	Present
John S. Farquhar, Ft. Wayne	Present
James A. Harshman, Kokomo	Present
Eugene S. Rifner, Van Buren	Present
Patrick J. V. Corcoran, Evansville	Absent
Kenneth O. Neumann, Lafayette	Present
Jack E. Shields, Brownstown	Present
Thomas C. Tyrrell, Hammond	Present

Guests:

Judge Ralph Hamill, Dean Irwin, A.C. Offutt, Richard Kilborn, J.M. Black, J.E. Holman, Norman Booher, Gordon Fessler, and Arthur Loftin.

Staff:

Robert J. Amick, field secretary
Howard Grindstaff, field secretary
John L. Walters, field secretary
Kenneth W. Bush, administrative assistant
Jas. A. Waggener, executive secretary

Minutes of the meeting held February 7th. **Dr. Hillis called attention to some inaccuracies in the minutes which were corrected and finally approved on motion of Dr. Hillis, a second by Dr. Gattman, and approved as corrected.**

Reports of Guests

SUIT AGAINST BLUE CROSS—JUDGE RALPH HAMILL. Judge Hamill read a letter received from Blue Cross-Blue Shield under date of February 9th in which the Blue Cross Plan had agreed to discontinue the statement providing professional services in their policies and he felt that the matter had been resolved. He did recommend that rather than dismissing the case at this time that we can petition the court to make an entry of a court judgment to the effect that this would constitute practice of medicine, therefore, is objectionable and it should not be incorporated in any future policy. He therefore recommended that for all practical purposes, if we can get the court to enter such a decree, which would have the binding effect of law, that this would conclude the case. They would therefore be prohibited from providing physician services and they cannot advise that they provide physician's services. At the present time they have promised to have this out of all of their policies by the middle of April.

The matter was discussed by several.

CHAIRMAN: I will entertain a motion that we will continue in the vein we have just discussed, namely, that Judge Hamill will pursue an attempt to get a court decree relative to this proposition as stated and he will not allow the suit to be dropped, pending the outcome of this type of decree.

The motion, as outlined by the chair, was made by Dr. Reid, seconded by Dr. Gattman, put to vote and carried.

IHA Representation on Commission on Emergency Medical Services

JOHN S. FARQUHAR, JR., M.D., chairman of the Commission on Emergency Medical Services appeared before the Board and requested permission to make official appointments with the right to vote to a representative of the Indiana Hospital Association.

Following discussion of this matter, a motion was made by Dr. Santare, seconded by Dr. Clark, that this be permitted. Further discussion was then had concerning the constitutionality and another motion was made by Dr. Ingram, seconded by Dr. McIntosh, that they be granted representation but without the right to vote. Following further discussion of this motion, a motion was made by Dr. Hillis to table the entire matter. The motion was put to vote and carried.

Blue Shield Report

MR. RICHARD KILBORN: I have three matters that I would like to bring to your attention today. First, the Internal Revenue Department has issued an ultimatum that effective beginning January 1, 1970, all carriers for Medicare and Medicaid will have to issue IRS forms 1099 to the Department of Internal Revenue Service and to physicians and other suppliers of services for all services rendered after January 1, 1970. Likewise, the Internal Revenue Service has informed us that effective January 1, 1971, all health insurance carriers will also have to issue 1099's to physicians. This means that for the year 1970 under Medicaid and Medicare, we will have to report to IRS the amount of the monies paid to physicians under these programs. They are even discussing the possibility of requiring us to also report as income to physicians and other suppliers the amount of money reimbursed to individuals for the purchase of physician's services and other supplies. This means

that we will have to report, using the physician's Social Security number and identification number, that we have requested physicians to supply us with this information.

The question was asked if this covered only the individual physicians instead of corporations and Mr. Kilborn answered in the affirmative.

MR. KILBORN: We have also been informed by IRS that we are to supply the department with names of physicians who refuse to give us their number.

The second point I would like to discuss is the program by the association recently approved with the Board of Trustees. We have been literally swamped with calls concerning this program and I would like to report to you that generally once a physician knows what has happened, he is very appreciative. The program the Board of Trustees decided to offer to the physicians throughout the state is an excellent program and once the physician really understands what he is being offered, he likes it, however, he is not happy about the total cost.

QUESTION: Are you completely phasing out the program which they have previously had or can they continue with the coverage they have? Expressly, if they have a major medical policy and do not want this comprehensive plan, there is no opportunity to continue on as they are?

MR. KILBORN: That is right. They have three options. They will have available to them the comprehensive program, including the major medical; the $250 deductible major medical, or the $500 deductible major medical.

The final matter on which I want to report to you is Medicaid. There seems to be some interest in the figures in the number of providers who have signed the blanket assignment form. There is a total of 5,652 doctor providers signed as of this date of which 2,348 are M.D.'s and D.O.'s; 682 dentists; 648 suppliers; 951 pharmacists; 539 optometrists; 215 chiropractors; 134 podiatrists and 134 miscellaneous suppliers. So far we have paid 58,796 claims for a total of $265,776.48. We do have a backlog of claims and we hope to make two payments this month in order to try and catch up. We have 31,548 claims ready to pay totalling at least $190,000. We hope we can get 20,000 claims ready so we think the total payment should run between $210,000 and $215,000. For the entire month of March we are almost sure we will put out between $400,000 and $450,000. A breakdown of this amount in round figures: $1,500 for drugs; $60,500 for physicians; $20,000 for dentists; $160 for podiatrists; $80 for chiropractors; and another $10,000 for miscellaneous items. We also wish to report to you that not a single faith healer has signed up for the program.

DR. SCHUSTER: One of our counties has requested us to determine how large an area is involved in establishing the 75%. Is this on the county basis? Is this on a specified locality and if so, is it possible for this locality to be given what the average for the 75th percentile is for that locality?

MR. KILBORN: I think we have approximately 12 regions. Now those regions are not necessarily geographically together. We might lump, for example, Indianapolis, South Bend, Evansville and Fort Wayne as being one district. The reason for this type of lumping is because our experience of the charges in these areas are very similar. I want to reemphasize that even though we have these 12 or 13 districts, there are very few procedures that will vary from district to district.

I am not sure about whether I can give out the information as to what we consider the 75th percentile as it would be extremely difficult to get a computer printout for a given area. Finally, I think we would defeat the whole purpose of the whole program of this nature by so doing. I think we want to remember that we built in the protection for the medical profession first by designing the agreement which says he can cancel it at any time so he is not committed to anything unless he signs a claim. Secondly, it is understood and the manual plainly indicates that he has a medical review mechanism available at both the county society level and at the state society level, should he be dissatisfied with our determination of the 75th percentile. In addition, he has legal mechanism, the same as the patient, for a formal hearing in case of any dissatisfaction with payment for his services.

DR. SCHUSTER: In the past it has always been clear as to what the Welfare Department would pay for the physician's services and therefore physicians wonder why this type of information is not available at this time.

MR. KILBORN: Prior to January 1, 1970, the Welfare Department at the county level and the county medical society negotiated their own fee schedule for that particular county. The whole idea in the usual and customary program is the fact that the physician continues charging his usual and customary basis and any time you give out information as to what the 75th percentile is, obviously you are going to influence certain doctors in their charging practice. This defeats the whole idea in the usual and customary concept and winds up being a fee schedule.

The matter was further discussed by several.

Report of Dr. Glenn W. Irwin, Jr., Dean, I.U. School of Medicine

DR. IRWIN: I would like to announce that next month we are planning to hold Alumni Day in conjunction with the dedication of the new University Hospital at which time I am expected to give a "State of the Union" address. This will be in written form and presented to this group. I would like to distribute at this time a copy of the resolution adopted by the Governor's Commission on Medical Education.

RESOLUTION FOR A STATEWIDE MEDICAL EDUCATION PROGRAM

WHEREAS, there is serious need throughout the state of Indiana for greater numbers of practicing physicians and allied health care professionals,

WHEREAS, the Indiana University Medical School has expanded to meet the need but finds it difficult to satisfy the ever-increasing demand for qualified persons to deliver health care services,

WHEREAS, the public and private institutions of higher education and the community hospitals throughout the state are capable of absorbing additional students for training in the health care services at an early date,

WHEREAS, the retention within the state of Indiana of those trained in health care services, particularly physicians, becomes increasingly more difficult,

WHEREAS, building a second medical school would require a delay of approximately ten years before increasing the number of graduating physicians, would cost an amount exceeding the current financial capabilities of the state, and would materially benefit only one limited area of the state,

WHEREAS, multiple medical education centers will attract students, interns and residents to the several geographic areas, thereby attracting increased numbers of practicing physicians, encouraging development of health care facilities, providing for the training of additional numbers of allied medical personnel, and increasing capabilities for the existing program of graduate and continuing medical education,

THEREFORE, BE IT RESOLVED, that the following actions be approved:

1. That new funds be made immediately available for the appointment of directors and planning staffs at those institutions of higher learning and at

those medical centers in the communities of Lake County, South Bend, Ft. Wayne, Muncie, Lafayette, Terre Haute, and Evansville for the year 1970-71.

2. The investment of the administration of the Indiana University School of Medicine with the responsibility and authority for planning and implementation of an orderly expansion program in concert with the planning staffs.
3. The admission of medical students in 1971 to those centers which in judgment of the school of medicine have developed appropriate faculty, facilities, and curricula which are considered to meet those accreditation standards of the Liaison Committee of Medical Education representing the Council on Medical Education and Hospitals of the AMA and the AAMC, (Association of American Medical Colleges).
4. Joint faculty appointments by the Indiana University School of Medicine and other institutions of higher education be made. Indiana University School of Medicine will provide admission procedures, curricular development and accreditation. The establishment of a system of evaluation must be made to insure continuing quality of the educational program.
5. The acute needs of the Indiana University Medical Center for augmented physical facilities and additional faculty must simultaneously be met in order to insure the continuing high quality of education to the increased number of students for the health care professions under this plan.
6. The Governor's Commission on Medical Education recognizes its responsibility for continuing review of medical education toward the early and effective implementation of this plan.

Unanimously approved this February 11, 1970 by the Governor's Commission on Medical Education.

This resolution, if you have read it, in a sense expands considerably the statewide medical education program that has been operational since 1967. For the first time, we are getting into undergraduate or medical student programs in a formal way. I am sure you are aware we have had entering medical students on four campuses throughout Indiana: here in Indianapolis, Bloomington, Purdue and Notre Dame. The latter two are strictly pilot programs and while they are not particularly successful, we have learned a good deal.

It is obvious if a portion of medical education is to be given at our state universities and at Notre Dame, that a more formal arrangement must be provided than we have had in the past. We feel that the program at Bloomington has been a model in which all basic medical sciences are provided over a two- or three-year period and also in which introduction to medicine and physical diagnosis is offered. It seems to me that the charge to the school of medicine by this Commission on Medical Education is to establish other Bloomington-type programs so that an increase in the entering number of students can occur. No formal decision has been made as to whether a student entering a medical education program will spend one year there or two years there on one of the regional campuses. From a faculty standpoint here in Indianapolis, we feel that essentially all of the basic sciences must be offered. There will obviously be a big bottleneck and fortunately Doctor Black, a member of this commission, stressed this a great deal at the last meeting of the commission.

I think one of the keys in this resolution is the fact that no program can be instituted until it is accepted by the Council on Medical Education of the AMA and the AAMC because if a program is started and not approved by these two bodies, then we lose our accreditation, and are thus not eligible for grants to keep our doors open. While some have expressed the feeling this would be second class medical education, I am really more optimistic about it as I think there are several areas in the state that can offer good programs and the basics in medical sciences. I think there are other areas that can offer good clinical courses for medical students.

One must remember that the quality and the number of premedical students applying is really remarkable. We could have, for example, this September of 1970 literally have filled our class of 227 or more with 3.2 students if we had chosen to do so. We felt there are a lot of excellent students down below the 3.0 level so some of those will be taken. It is obvious that in a school like ours and in the other medical schools that thousands of qualified students are not going to be entered because of the limited number of physicians. I think we have a real obligation as a school to attempt to alleviate this problem because we need more doctors, we need more medical services, and we have the ability with this statewide program to accept more students into the system more quickly and at less expense to the state.

We have calculated that if we decide now that a second school of medicine would be created, it would take ten years before the first graduate would come out. It would take about one hundred million dollars, plus another twenty-one or twenty-two million dollars of operating money so that you would have an investment of about one hundred twenty-two million dollars before the first graduate came out of this school. In the meantime, with this program which we are talking about, we could have an additional 725 doctors graduating with this statewide system before the first graduate came out of another school.

DR. SCHUSTER: Are there funds immediately available or do you have to go to the legislature for funds?

DR. IRWIN: The Governor and the budget agency have indicated that $350,000 could be made available this next year in the '70 - '71 biennium.

Report of Dr. A. C. Offutt, State Health Commissioner

DR. OFFUTT: I am leaving five copies of Indiana's Emergency Medical Service Plan and if any of the Board would like a copy of this we will be happy to send a copy upon your request.

Regarding the measles vaccine program, at this time it seems the chances are good that we will continue to receive the vaccine and be able to distribute it to those societies requesting the vaccine. There is a ten million dollar increase in funding but rumor has it the president will not release these funds. This does not mean, however, that there will not be funds to carry on the program at this time.

I would like to discuss with you the present attitude and intense interest of the body politic in the matters of air and water pollution, the latter including thermal pollution and noise pollution, is beginning to get notice. I might tell you we are holding hearings over the state concerning the adoption of air quality standards and regulations. We have attempted to give all segments of the population a voice in these hearings.

Next I would like to inform you that there is a significant move on foot to reduce the overall Hill-Burton funding program. As we understand it, the category of grants for hospital construction may be discontinued and a loan system substituted therefor. We do expect there will be a significant reduction in the amount of funds for new construction and we will have some difficulty in meeting our commitments with respect to modernization. We are fearful that some of the commitments therefore cannot be met unless we are successful in obtaining additional funds.

The final item I want to discuss with you is Comprehensive Health Planning. I started talking about this at the seminar which was held here a couple of years ago —the fact that we must do certain things under the provisions of P.L. 89-749. I have also mentioned that as far as we are concerned, our counties that have Comprehensive Health Planning bodies will be utilized. I would also like to inform you that there is a Bureau of the Budget Circular No. A-95 which has been distributed which now requires that anyone who is going to spend federal funds for anything—highways, health, education or whatever, has to submit that to a clearing house, which in Indiana is the Governor's office, and with which we now have a working arrangement that any program which comes in for federal funding which has a health component will be submitted to us for our review and comment. Likewise a similar clearing house will be established at the federal level. I would like to close and stress not only the importance but the necessity of the medical profession becoming concerned and involved in Comprehensive Health Planning.

DR. McINTOSH: Do you think Comprehensive Health Planning is going to fade away?

DR. OFFUTT: I stood, I think, at this very podium and mentioned in the past that it is here to stay and it is going to be a way of life and if I ever had any doubts in my own mind, they have been dispelled. The law will expire in June and in December a new bill was written. I have seen the draft of the bill and, on reliable authority, it probably will not encounter any problem in passing the Congress. Comprehensive Health Planning is not only here to stay, it is going to get stronger and stronger.

DR. KINTNER: Can a new addition be built on the hospital or can two hospitals form an agreement, that is where you have an auxiliary county hospital taking over the previously existing hospital and make an auxiliary wing? Can this come to pass without going through the areas of the Comprehensive Health Planning group and having its approval?

DR. OFFUTT: The answer is "no."

QUESTION: In Comprehensive Health Planning you have a county group in which we were originally organized and we now form a regional group. Are you going to get some guidelines as to where they should be or should not be overlapped? For instance, in the county group you have task forces, health facilities, manpower, mental health, emergency services, and then you have a council and you have an executive committee. Are these going to be set up in each county and then at the regional level? You need an awful lot of staff to cover meetings, etc.

DR. OFFUTT: The in depth organizations in the counties will not, cannot, and probably should not be anything like the regional. The feeling is that the region should know and should have an opportunity to comment on county projects. If a difference exists between the county and the region, the State Comprehensive Health Planning Committee will settle it.

DR. HILLIS: Where is all this business going to originate?

DR. OFFUTT: I have had this question many times—"We had a meeting and we did not know what to talk about." I just think the problem lies in the breadth of Comprehensive Health Planning and I have used a simple example. That if you, as a physician, have ever said "I wish we could do something (build a school house, build a satellite hospital, put sewers out for new suburban areas) this is something for you to talk about because this is Comprehensive Health Planning because of the overall effect.

Discussion was continued on the importance of Comprehensive Health Planning and the question of the feed lot problem in counties adjacent to Marion County.

DR. INGRAM: In the original idea of Comprehensive Health Planning, particularly related to Regional Health Planning Councils, there were some goals stated that had to do with the placement of medical personnel. Is there anything that you can see in the future where these groups might try to take action in this area with the actual placing of personnel?

DR. OFFUTT: As far as the planning people are concerned, the answer to your question is a flat "no." There are others who are discussing this as a possible activity. I am happy that you asked this question because you have made it possible for me to re-emphasize something I said before. Organized medicine cannot afford to watch the parade. They have got to get in the parade and you have just mentioned one of the reasons.

There are some people who feel that all the social problems of the world can be charged to the delivery of health care and they support some kind of assignment plan in placing physicians in areas where they are needed.

CHAIRMAN: If there are no other questions of Dr. Offutt, we will proceed to Reports of Officers.

Reports of Officers

DR. SCAMAHORN, PRESIDENT-ELECT. The president-elect of the Indiana State Bar Association and I happen to be from the same county and he has been my family's lawyer for several years. In talking to him he has been greatly concerned with the malpractice problem. In our discussion, we would like to proceed, with the approval of this Board, and with approval from his association, that we have a rather high level conversation, perhaps using the Inter-Professional group, Medical Economics and Insurance Commission, or some of these people in getting something done about the malpractice problem in the state of Indiana. He would like to take this as more or less one of his platforms. He was not aware that many young fellows from the bar as well as medicine going into solo practice have a difficult time in obtaining this coverage. He also was concerned about the extremely high unreasonable judgments that we are getting in a few cases, although he has some mixed emotions about the question of contingency fees. I would like an expression from the Board as to whether they feel I should proceed and get busy in pursuing this further.

A motion was made by Dr. Schuster, and taken by consent, that Dr. Scamahorn should pursue these discussions.

CHAIRMAN: We will now hear the treasurer's report.

DR. HOYT: In your handbook is a complete treasurer's report. You will notice on the first page, it shows that we have $37,000 in the checking account. You will note that the funds are listed on this page showing the amount of money in cash and investments, the total amount of all funds of the association. In addition is the page showing our investments, our investment portfolio, and an operating statement for the association and *The Journal*. **I move the acceptance of this report. The motion was seconded by Drs. Gattman and Scamahorn, put to vote and carried.**

CHAIRMAN: We will now hear from the editor of *The Journal*.

DR. RAMSEY: I do not have a report, Mr. Chairman, unless there are some questions.

CHAIRMAN: We will now hear the report from the AMA delegates.

DR. SENSENY: I am somewhat personally distressed to tell you this but I guess everybody should know that Dr. Wood is withdrawing himself as a candidate for the Board of Trustees in June so this basically leaves us without any personal or direct political cause at this time. I would certainly hope the Board of Trustees would support and put in resolutions

from the state of Indiana and hope that we might have these before the meeting in June. As far as the AMA delegation is concerned, I have nothing further at this time but would like the privilege of asking either Dr. Frank Green, Dr. Wood, Dr. Farquhar or Dr. Shields if they would like to address the trustees.

A further discussion was held concerning the political situation in the AMA as it relates to the presidency of the Board of Trustees.

On motion of Dr. Smith, seconded by Dr. McIntosh, the motion was made that the Executive Committee and the AMA delegates get together within the next 30 days and see if they could crystallize some ideas concerning a possible candidate from the Indiana State Medical Association for election to the Board of Trustees.

Matters Referred by the Executive Committee

CHAIRMAN: We will now move on to matters referred by the Executive Committee. In the absence of Dr. Kerr, due to the illness of his daughter, Dr. Petrich mentioned there had not been a meeting of the Executive Committee but there was one matter which was not discussed by the Board at its last meeting. That was the matter of the letter from Dr. Tyler in which he had stated he had approved the Himler Report in its entirety. This was referred to the Board by the Executive Committee for possible action and the recommendation that an ad hoc committee of the Board be appointed by the chair to study and to devise any resolution from the results for presentation in the AMA meeting in June. This report has been sent to the membership at large by our headquarters office and in my observance the report has not even been looked at, much less studied. Therefore, I would like the opinion of the Board as to whether or not you feel we should appoint a committee of this Board to handle this matter. Does anyone have a similar feeling one way or the other? My feeling, for what it is worth, is that it is being handled in various ways and there was no reason for the Board to have an ad hoc committee.

DR. GOSMAN: I move we do not follow the recommendation of the Executive Committee. The motion was duly seconded by many, put to vote and carried.

Reports of Trustees

DR. AUSTIN—1st District. No report.

DR. DUKES—2nd District. No report.

DR. REID—4th District. Only a general comment. The problems of medical malpractice has created more discussion in my district than anything that has occurred since I have been a trustee. There is tremendous interest in this subject.

DR. SMITH—6th District. The district meeting speakers will be Dr. Glenn Irwin, Dr. Otis Bowen, and Congressman Richard Roudebush. I would like to extend an invitation to all of you.

DR. GOSMAN—7th District. No report.

DR. SCAMAHORN: I would like to add to Dr. Gosman's comments that the district meeting will be held in the Ulen Country Club in Lebanon, with Dr. Hanna and perhaps one of the 500 Mile Race drivers talking on "Safety." Also we will have golf during the day.

DR. SCHUSTER—7th District. No report.

DR. INGRAM—8th District. No report.

DR. PETRICH—9th District. The 9th District meeting will be held in Crawfordsville on June 11th.

DR. SANTARE—10th District. The 10th district meeting will be on May 13. Arrangements are being made to hold it at Phil Smidt's in Hammond. **I would like to request remission of dues of a member from the Lake County Medical Society because of illness and his inability to practice at this time. I so move. Motion was seconded by Dr. Ingram, put to vote and carried.**

DR. HILLIS—11th District. No report.

DR. CLARK—12th District. I would be very happy to meet with all the societies in my district but feel I should go upon invitation. There is feeling in our district that more publicity should be put out regarding the "Teen Health Happening" on April 23-24.

PRESIDENT: The "Teen Health Happening" has been publicized in the meeting of the House of Delegates last October and on several occasions. It has been discussed at every meeting of the Board since the meeting last year. Information has been sent to the presidents and secretaries of all component county societies as well as the presidents of all the county auxiliaries. Also brochures have gone out to all the high school principals and many other organizations throughout the state.

DR. GATTMAN: I request from LaPorte County the remission of dues of two members of the LaPorte Society. Both of these gentlemen have retired from practice and I so move their dues be remitted. Motion was seconded by many, put to vote and carried.

DR. GOSMAN: A letter has just been handed to me concerning a matter for the Board to discuss. It reads: "The members of the Johnson County Medical Society hereby petition the Board of Trustees to transfer the membership of Dr. William G. Hibbs from active membership to senior membership in the state association. We believe that the 20 year membership requirement in the Indiana State Medical Association should be waived in view of the fact that Dr. Hibbs has been a member of the AMA for 50 years, a member of the Illinois State Medical Association for 34 years, and the Indiana State Medical Association for 16 years. Dr. Hibbs is 77 years of age and we believe deserving of this status." The letter was signed by Dr. Roller of the Johnson County Medical Society. **I move that Dr. Hibbs be given senior membership status. The motion was seconded by Dr. Gattman, Dr. Reid, put to vote and carried.**

CHAIRMAN: Before proceeding with the agenda, I recognize Dr. Wood.

DR. WOOD: Chairman, doctors of the Board, this is a little report that I have sent to the Education Commission and have discussed with your president and have made arrangements to have the syllabus mailed to each of you. As you know, we have had great criticism in the past about lack of proper training in the fields of medical economics and jurisprudence at the medical school. I have tried to carry on this course at the university and never was able to get it on the curriculum. They put it in the book but never let me have time on the curriculum. We finally got down to brass tacks and they decided that maybe we should put it on and so for the first time it has been put on the sophomore schedule under the title of "Medical Ecology." The course started last Thursday morning at 8 o'clock and we had all of the sophomore class there plus a few more.

The Dean of the Law School, Cleon H. Foust, gave an hour and a half of beautiful description of basic legal problems, as far as they are related to the young medical student. He was well received and did a very good job. Dr. Roy Behnke talked on "Medical Ethics and Social Responsibility." He also discussed "Medicine and Religion" and the responsibility of the doctor to society as a whole. We then had a discussion concerning transplants which was under a panel composed of Dean Foust; Rev. Wm. H. Hudnut, III, pastor of the Second Presbyterian Church; James O. Ritchey, M.D., and James Donahue, M.D. It was very well received so I think you can have a feeling that the medical students are now being given some real insight into the problems of the physician.

The second day the first lecture was given by Dr. Howard, Executive Vice President of the AMA, who discussed the organization of the AMA and the current problems that are facing American medicine. He fielded questions for some 20 minutes following his presentation with questions such as "How can you support your concept that the fee-for-service basis is a better program for better health care than a prepaid medical group plan?" Due to the action of the executive secretary, you will notice that we had an article on the first page of the second section of *The Indianapolis News* which gave us quite a story on Dr. Howard's presentation. It was a thorough and factual report. It was great.

Dr. Wood then went through the rest of the agenda for the balance of the program concluding with a statement that we have launched a dialogue with the medical students and if we can get one point over and that point is "that organized medicine cares just as much about the problems that affect the health of the people of the United States as any medical student ever thought about, and perhaps we have more concern than they ever thought about." If we can get this over and have them understand that we are willing to talk, that we don't have all the answers and the answers are not easy answers as they might think they would be, I think we will get very good doctors out of Indiana University.

Reports of Commissions

DR. HOLMAN, chairman of the Commission on Governmental Services. Thank you, Mr. Chairman. In January we met with Mr. Waggener and he suggested some plans for the commission to follow and that was to find an alternate plan for Medicaid. We have done nothing except listen and try to learn something. I don't know whether we will find an alternate plan. I have been to a few meetings and I found this list about the doctors who have signed up in the state of Indiana and the doctors who have not. Marion County has 287 signed up out of a 1072 membership. In my office, I have not signed up myself. Our office receives four or five calls a week wanting to know if we take patients under Medicaid and I say "no" and many times I hear this answer, "Well I have the money to pay for it . . . . I will call for an appointment or something."

Another project of our commission is the review of CHAMPUS claims. At the meeting in January we approved 13 claims and had about 11 others the 1st of February. We had a meeting here last week where we reviewed 17 claims and we are doing it a little differently now-a-days. We have a telephone conference with our committee at 10 o'clock. Mrs. Hollingsworth, who takes care of these claims, photostats all the information that is sent from the doctor and she sends it to the committee about a week ahead of time so we have a chance to review it. We then come together on the telephone in Mr. Waggener's office and we were through at least 17 claims in about 75 minutes. As far as I am concerned, this method has been very satisfactory.

The claims that we review are the ones on which staff in the office feels professional opinion is necessary and one for procedures which sometimes they cannot find a pigeon hole in which to put them. The staff cannot sometimes categorize them and find a way to justify the fees that are charged. The office has been accused of arbitrarily setting the fees. We do not arbitrarily set the fees. On the other hand, we try to justify any fee that any doctor requests. Oftentimes the information we receive from physicians is very meager and many times, if unusual circumstances are involved, he makes no notation to assist us in perhaps paying him more because of such circumstances. We do write back for surgical reports on most of these cases. We try to contact them if they feel we have not given them a fair chance. We have some unusual situations.

One case is a woman who put in drug bills for six months and the computer in Denver, where all these reports are sent, kicks out a claim if somebody spends more than $200 per year for drugs. In this case, the woman was getting prescriptions from two physicians here in Indianapolis. She would get one from one doctor one day and one from the other doctor the next day. Our committee did not know what to do but decided to write each of them a letter, send the same letter to both of them and say that this woman has made a claim for drugs with no medical claims for physician's services and were you aware that she was having prescriptions written from so-and-so doctor? This happened about two months ago. I saw one of the doctors the other night at our medical meeting and he said "Say, I sure thank you for that letter. I didn't know what was going on. I got hold of the other doctor and we have agreed on what we are going to do." Well we have made one good move anyway.

We had another fellow who had a whale of a drug bill. He was getting two or three bottles a day, two from the drugstore and one from the doctor. We have written this doctor and asked if there is any other way to handle this. We have not heard from him as yet. We have been in contact with the anesthesia group in the state of Indiana and intend to renegotiate a new contract for anesthesia with the government for the CHAMPUS program. Our commission would like to have copies of the California Relative Value Schedule for information and I feel we could possibly use these if you feel free to authorize the purchase of these booklets.

CHAIRMAN: I now recognize Dr. Senseny, chairman of the Commission on Legislation.

DR. SENSENY: I have only to report to the Board that the initial meeting of my commission will be held on May 24th.

CHAIRMAN: I recognize Dr. Booher, chairman of the Commission on Voluntary Health Agencies.

DR. BOOHER: I would like to report that at the regional meeting held in Indianapolis last October, we had representatives from 11 states attend the meeting. In letters from other states, they have indicated that the conference resulted in their forming similar committees to our commission in their respective states. I would also like to report that your commission will again conduct a program as a part of the annual meeting of the Indiana Public Health Association April 21-23. Our portion of the program will come on Thursday morning and all the speakers this year will be from the Indiana State Medical Association. I would like to urge the Board to encourage as many physicians as possible in their respective districts to attend this meeting as we are constantly being criticized for lack of medical participation in working with these people who are busy in the various health programs in our state.

There is one important matter I would like to call to your attention and that is President Nixon's inauguration of a new program which we think holds a lot of promise. Some of you have noticed that Mrs. Nixon has been making trips to colleges, primarily, but this thing is a national group which the President has set up administratively with a very potent board. It is headed by people of cabinet rank. Their effort is to bring together all the voluntary forces in the United States, seeing where they can be applied to government programs or to supplant them and whatever they can work out with government programs to enhance them.

I would also like to report that the Commission on Voluntary Health Agencies held a joint meeting of the Commission on Public Information and we

have jointly requested certain action from this Board. We would like to request that we obtain a legal opinion concerning the wording on the placard which we send out announcing the approval or rejection of certain agencies by the commission of the Indiana State Medical Association. We would like to know if legally we can use the word "approve" rather than the word "recognize," and further, if we may distribute this placard to the Chamber of Commerce and groups other than physicians. I would also like to report that our commission is currently working with the voluntary agencies in determining if we can plan a Health Council in Indiana somewhat patterned after the one in Michigan.

CHAIRMAN: If there are no questions of Dr. Booher, we will next hear from the Commission on Convention Arrangements, Dr. John Ferry, chairman. Dr. Ferry is not able to be with us but has prepared a written report for presentation to the Board. You will note the report points out there will be a continuous program on Wednesday and Thursday under the supervision of Dr. Beering of Indiana University. It will be a continuous program in separate rooms which doctors may attend at any time and visit as many of these sessions as they desire. You will also note the commission recommends that fraternity luncheons be dispensed with because of a lack of interest in the past.

Secondly the commission requests that the Board of Trustees consider their policy with respect to appearance of speakers on the program from within the state. They request that we provide a $100 per day honorarium for in-state speakers but not to provide them with travel and housing expense reimbursement. They are perfectly willing to go along with the previous arrangements which provides that out-of-state speakers be given a $100 honorarium and their expenses, and if they speak on two separate days, that the honorarium be increased to $200. **I will entertain a motion on the commission's request for paying an honorarium to in-state speakers.**

DR. REID: I so move. The motion was seconded by Dr. Hillis.

CHAIRMAN: Is there a discussion?

DR. HOYT: I think this is a serious step and will drain our treasury and it is unnecessary. Certainly our own members ought to be willing to contribute their time. They should be in the meeting anyway. I would be against this motion. I think in fairness though to Dr. Ferry, he should be heard before we vote this down.

The matter was further discussed by members of the Board and Dr. Gosman moved that the motion be tabled. The motion was seconded by Dr. Clark, put to vote and carried. The motion was therefore tabled.

CHAIRMAN: I would entertain a motion to refer this back to the commission for further consideration.

DR. GOSMAN: I so move. The motion was seconded by Dr. Smith, put to vote and carried, to refer the matter back to the commission for further consideration.

CHAIRMAN: The commission has also requested that the trustees help publicize the meeting in South Bend since the trustees represent all areas of the state. The commission says they feel that the Board of Trustees should lead the way in demonstrating interest and duty in attendance at the meeting and should set a good example for other members.

We will now hear the report from the Commission on Constitution and Bylaws, Dr. Fessler.

DR. FESSLER: We have previously distributed our report to this Board and we find ourselves in the middle of throwing a monkey wrench into your plans every once in awhile.

The last action of the House of Delegates did not conform to your Constitution and Bylaws. The action taken was out of order. The end result was the House passed something which has no legal basis so it was dumped in our laps and we have wrestled with it. We can make it legal. In our report, if you have read it, it was pointed out you did not even have a resolution to start with or an amendment to the Constitution and Bylaws. It was just a recommendation which was misplaced and finally, one that the House of Delegates deleted the question of even referring this proposed plan to the Commission on Constitution and Bylaws or to the House for the purpose of amending the Constitution and Bylaws. We find the action of the House of Delegates in conflict with Article VI, Article IX, sections 1 and 5; and Article XIV of the Constitution. We also find the action inconsistent with the Bylaws as laid out in Chapter V, section 5; Chapter VII, section 1; Chapter XVIII, Section 4; and Chapter XXXIII. We have made the following recommendations for presentation to the House of Delegates in October:

Be it resolved, that in Article VI, the last sentence, "Seven trustees shall constitute a quorum," that this be deleted and replaced by "A majority of elected trustees shall constitute a quorum."

We also recommend:

Be it resolved, that in Article IX, Section 1, the first sentence, that the word "thirteen" be deleted and the word "the" be substituted.

Be It Further Resolved, that Article IX, Section 4, be amended in the second sentence—the word "Trustee" be changed to "Trustee(s)" with a small "s" in parenthesis and by adding "Alternate Trustee(s)"—which will make the second sentence read in part, "If any district fails to meet and elect its Trustee(s) or Alternate Trustee(s) by the time of the expiration of the incumbent's term of office.*****"

Be It resolved Article IX, Section 5, be amended by making the first sentence to read, "Each Trustee district shall elect Alternate Trustee(s) (with the "s" in parenthesis) whose term of office shall be the same as the Trustee, namely three years." The remainder of the section to remain the same.

We make the following recommendations to be made in the Bylaws:

Be it resolved, that in Chapter XXVIII, Section 4, of the Bylaws, be amended by adding "(s)" following the words "Trustee" and "Alternate Trustee" wherever it appears in the first sentence of this section and that the last sentence of this same section be amended by adding the "(s)" after the word "Trustee."

Be it resolved, that in Chapter XXVIII, a new Section 5 be inserted, and the present Section 5 be renumbered "6" and Section 6 be renumbered "7" and so on to the end of the chapter. The new Section 5 would be, "Sec.5. Each district shall have one Trustee and one Alternate Trustee for each 600 active members, or major fraction thereof; but in any event, each district shall have one Trustee and one Alternate Trustee. The term of each Trusteeship newly created by the numerical growth of the district shall begin after the next succeeding annual meeting of the House of Delegates (in accordance with Chapter VII, Section 1.)"

I was unable to attend the last meeting of the commission due to the storm, but the question was brought to the commission at that time about any of the component county societies wishing to invite the ISMA to hold its annual meeting in its locality should submit an invitation in writing at least five years in advance to the Board of Trustees who shall make an investigation of the facilities and in turn recommend to the House of Delegates the recommendation for our annual meetings. Your commission feels this has merit and therefore will propose a change in the Constitution.

The commission also discussed the

method of calling special meetings of the House of Delegates, and we believe that in order to make a special meeting of the House of Delegates coincide with various areas of the state, we are suggesting that a change be made somewhat as follows: "Upon receipt by the president of a petition for a special meeting of the House of Delegates, it shall be called by the president upon petition of 30 delegates or 100 members; the signed petition of 30 delegates, including no more than 5 delegates from any one trustee district, or 100 members, including no more than 15 members from any one trustee district."

This completes the report of our commission, Mr. Chairman.

CHAIRMAN: We have two items of business which Dr. Fessler has presented to us. The action of the Constitution and Bylaws Commission on the trustees and the second item regarding the site of the annual convention being decided by the Board of Trustees and the recommendation to the House of Delegates. Is there any discussion? If not, I would entertain a motion relative to Dr. Fessler's commission report concerning the selection of the site of the annual convention.

DR. SANTARE: I move that we accept this report. Motion was seconded by Dr. Smith, put to vote and carried.

CHAIRMAN: The second item deals with special meetings of the House of Delegates.

DR. McINTOSH: I move the acceptance of this portion of the report. Motion was seconded by Dr. Smith.

CHAIRMAN: Is there discussion? The matter was discussed by several.

DR. INGRAM: I move to table this motion.

CHAIRMAN: Dr. Ingram has made a motion to table. There being no discussion on a motion to table, all those in favor say "aye." We will have to have a show of hands. All those in favor? All opposed? The vote is a tie, therefore, the motion to table loses. We will continue the discussion. The matter was further discussed.

DR. SCHUSTER: I move to amend the commission report to read "That no more than 10 delegates or 34 members from each of at least three Board districts be necessary to call a special meeting of the House of Delegates. The motion was seconded by Dr. Gattman, put to vote and carried.

CHAIRMAN: We will now review the printed report of the Commission on Public Health.

DR. GOSMAN: I move that this matter be referred to the Commission on Public Health to act on these matters. The motion was seconded by Dr. McIntosh, put to vote and carried.

Remarks of the President

DR. STEEN: I propose to convene the House of Delegates in special session tomorrow and immediately ask that the House be seated as a committee of the whole to discuss the three resolutions which are to come before it.

For a number of years several of us in this room have been critical of this association for their failure to answer criticism of the profession. The Trustees were in Chicago on February 9 at which time the Senate Finance Committee's report was released to the public. Senator Hartke made comment which was picked up by all the newspapers. Almost before I was out of bed on Monday morning at the Palmer House, Jim Waggener was on the phone and he had already been in contact with the Senator's office several times that morning in an attempt to get the names of the five physicians from Indiana who were named. Jim asked for permission to release a statement to the press. He read it to me and I authorized its release. He also asked if he might appear on a local television station and I agreed to this.

Subsequently, he taped six radio broadcasts for local television stations and I taped five myself by the time I got home the next day—some for Lake County, one for Terre Haute for the Indiana State University radio station, one for South Bend, and I had communicated with a large number of newspaper people from throughout the state who called me. We also that day, the second, Tuesday, released a press release over my signature. At any rate, the point I wanted to make was that of the five doctors listed, one we knew was already indicted for fraud. This doctor is in the process of having his license revoked. Three of the other four were from my own county and I have subsequently discussed this with our trustee and with the president of the county society and I guess they plan to have some further investigation although it is really superfluous because all of these welfare charges, in Lake County at least, have been reviewed by the indigent review committee before the fees are paid. So, in essence, there is no wrongdoing and I think this point has to be made very clearly. I don't want to pat my own self on the back, but I do want to pat our staff on the back for getting on this thing immediately and for getting some answers before the public as expeditiously as we did.

A week or two later, we were in Washington for the Public Affairs Seminar and the IMPAC meeting. Several of us went to see Senator Hartke, at which time we had a long discussion with him. I don't think we changed his persuasion any, but I think we gave him some facts and opened his eyes about some things and he was really quite defensive when we attacked him for what he had said about the doctors. He then provided us with his original press release which was really nothing like what appeared in the papers . . . the newspapers had a heyday with what Senator Hartke had said. Actually, his press release was rather commendatory of the doctors in Indiana. I would hope that we could continue to do this.

I yesterday dictated a letter to the editor of the *American Medical News*, who very liberally short-changed Indiana in a two-page spread this week in which they cited all the action on the part of other states in combatting this thing. They had given us a little room a week or so before in a front page article with a number of other states, but when you stop to think of the few people we had listed in the Finance Committee's report and when you stop to consider the manner in which we did get on this thing and justify the original stand, I think the *AMA News* gave us a rather short strip and I told them so. I think that is about all I want to say today.

CHAIRMAN: I would like to announce that the I.U. School of Medicine has received $28,861.39 from AMA-ERF for the calendar year of 1969.

I also have a letter from the State Medical Society of Wisconsin concerning testing of swimming pool water and if there is no objection, I will refer this to the Commission on Public Health.

Report of Board Committees

Board Committee on Medical Education and Liaison with I.U. School of Medicine —P. R. Petrich, chairman:

I have written to the Dean and have met with the Assistant Dean, Dr. Beering, and Dr. Murray relative to item (a) Physician Assistant Program. They do have in the works a program at I.U. relative to this and as I understand it much hinges now on who the new chairman is for the Department of Medicine, so at this point we have nothing definite. I would also like to announce that the Fall Seminar, with representatives from your association, the medical school and student body, has been scheduled for French Lick, September 19-20.

Board Liaison with Blue Cross—Dr. Santare, chairman. I have a number of things to report on and I will refer back

to the minutes about the nursing homes. The motion was to request the Board liaison committee to investigate the question of coverage on patients in extended care nursing home facilities. The motion was supplanted by a letter from Dr. Kerr, a copy of which was sent to the Blue Cross Hospital Services as well as myself. Blue Cross did have a meeting and I was unable to attend but my acting chairman was very willing to attend and sent me a report. The report that Dr. Neumann sent complained that physicians were not mailed a bulletin having to do with regulations covering extended care facilities. I believe this is one of the points you wanted to discuss with Blue Cross.

Blue Shield stated they did not believe that they could undertake the expense to print and distribute these to all physicians. Dr. Neumann pointed out that the nursing homes could mail them to the doctors in their area with Blue Cross replying they would encourage nursing homes to send them to physicians on their staff. Copies of the Physician Manual have been sent to the association for distribution to the members of the Board of Trustees. I received my copy from the office today. I have not received any from Blue Cross. We thought we ought to be acquainted with what the regulations were before we would proceed any further and we still have not been made aware of what the regulations were concerning extended care facilities.

The second matter which was referred to this committee was Resolution 69-12 and was brought up by Dr. Neumann and it provoked a long discussion. It was felt by Dr. Neumann that pre-admission testing should be allowed and to be done by any qualified, licensed physician, whether hospital-based or not. Dr. Neumann, also thought that Blue Cross could arrange with Blue Shield to develop some kind of a fund where Blue Shield could pay the physicians with Blue Cross funds. This received a very lukewarm reception from Blue Cross. Blue Shield has never said they would pay for pre-admission testing. The present program was developed solely by Blue Cross. Perhaps some leverage could be applied to Blue Shield in this respect. It was also pointed out that the hospital administrators in the Indianapolis area were not too keen on present tests. This is as far as we have carried out both resolutions.

Board Liaison Committee with Blue Shield—Dr. Dukes, chairman. The Board is trying to get the idea across that there is more Blue Shield in the doctors' offices than in the hospital, especially on the outpatient basis.

Board Committee of Business Consultants for The Journal—Dr. Dukes, chairman. No report.

Joint Board Committee on Governmental Medical Services—Dr. McIntosh, chairman: Last Thursday Dr. Offutt of the State Board of Health called a meeting between representatives of the Board of Health, the field staff of ISMA, Dr. Larson of the Governor's Committee on Comprehensive Health Planning, Dr. Shamberg, Robert Yoho, Mr. Waggener and I and also Mr. Gary Miller of Blue Shield.

The reason for the meeting was to develop better relations and communications with respect to Comprehensive Health Planning between the State Board of Health and the association. I think you are aware that we do have Blue Shield staff working on Comprehensive Health Planning and the obvious reason for the meeting was to get these boys to work for the State Board of Health. During the meeting I talked to Dr. Offutt and told him this was quite a switch from two years ago when I thought they were going to make a grant to us of $25,000 to do this type of thing. While it was never settled, I think it did make them think about it and jog his memory concerning this matter.

Dr. Offutt did mention some of the matters discussed this morning. One was that Comprehensive Health Planning is not going to go away and that we should get heavily involved in this program. It looks as though the Regional Medical Program will be underneath the Comprehensive Health Planning Agency and if this comes to pass, this is indicative of how powerful Comprehensive Health Planning can be. We do need to have control of it, I feel. As I said, I gained the impression that they wanted our Blue Shield and ISMA staff people to be at their beck and call and under control of the state committee. I am going to recommend that we do not put them under their control and keep them the way they are. I had talked to the president of Blue Shield and he has the same feeling that I have regarding this matter.

This report was discussed by several.

DR. STEEN: I would like to point out that this conversation is a discussion that has taken place in this room on several occasions and we reiterate the importance of this whole business of Comprehensive Health Planning and what it is going to do to us as physicians and the state association and it behooves us to keep Dr. McIntosh working.

Board Committee on Economics and Fiscal Matters: In the absence of Dr. Wilhelmus, Dr. Hoyt did not know of any report.

Report of the Joint Board Committee on Emergency Medical Services—Dr. Ingram will you report for this committee?

DR. INGRAM: The only thing I have to report is that Dr. Farquhar and I have discussed this by phone about our attendance at the legislation meeting. They have not met as yet. I understand I can attend if it is your wish but I understand he has discussed with the chairman of the Commission on Legislation the wishes of the Commission on Emergency Medical Services regarding legislation to be introduced in the 1971 session.

Joint Board Committee for Orientation of New Members—Dr. Clark: I have asked Dr. Ochsner and Mr. Walters to meet with the Dean of the I.U. School of Medicine to find out if it is possible for the school to work out an orientation program during the senior year of medical school. They have had a couple of meetings and I believe this might prove to be an excellent idea.

Ad Hoc Committee—Medical Use of Computers—Dr. Reid: I have put out these brochures which will be mailed to all of you and to all other doctors in the next couple of weeks. It is our first official mailing relative to this effort and will include a letter, copies of which also are directed to physicians only. We have operated now since last November.

We have had some problems with transmissions but hope to have it worked out within a week. We have about four hospitals which we think have finalized the arrangements to undertake transmissions as soon as the problem is cleared up.

Dr. Fisch at I.U. is to undertake the development of an evaluation program. Three cardiologists will independently read these tracings and will make a comparison and will be totally objective in terms of the effectiveness of the different systems. We have hired a business manager who goes to work next week. We are presently analyzing a program for encephalogram interpretations. We are currently discussing with the faculty of I.U. and Purdue the possibility of setting up an elective for computer medicine. It looks like we will receive good support from the medical school.

Joint Ad Hoc Committee on Education—Dr. Gosman: We did meet on February 15 and we reviewed that portion of the president's speech, the president-elect's speech and the items concerning the resolutions dealing with the delivery of health care in the state of Indiana and the physician shortage as well as peer review. We were fortunate in having Dr. Beering, as-

sistant dean of the university, who is a very active member of the committee, and Dr. Bryan, also a member of the State Education Committee, present. I can tell you briefly in leaving the meeting I definitely felt much better about the entire situation. There is much work yet to be done and Dr. Beering was hopeful that the medical association would assume leadership in these areas and lend their cooperation rather than the university itself taking the leadership.

We then discussed the peer review regulations, the activities throughout the nation in this field, and the delivery of health care, as you know, is a tremendous problem. Many organizations are working on the delivery of health care as well as a means of curing the physician shortage. These subjects, I believe, should be of tremendous interest throughout the state and I would like to make them a part of our district meeting programs. I believe it would be quite an education for our membership because it is the old, old story—we sit here and we know a lot about this but yet the groups out in the smaller areas or even the large areas don't know what these are all about.

CHAIRMAN: Your suggestion about putting this on the program in the district meetings is a good one and I would hope the trustees would be encouraged to attempt to get some discussion going at the district meetings on these subjects.

DR. STEEN: In my speech to the House I solemnly urged that a statewide peer review committee be established by the House for the purpose of education and to be a repository of information to serve as an educational bank for county societies who wanted to get peer review going. This would also serve as a stimulus to try and get them interested in the matter of peer review. This was, as you remember, tabled. Now later, from the Board of Trustees, it was stated I was going to appoint an ad hoc committee composed of members of the nine existing peer review committees to serve in this capacity as consultants to county societies who are interested in learning about it and who are interested in plunging in the cold water. Somehow with all my paper shuffling, I have not written these people yet. This will be a committee appointed by me, which is my prerogative, and we will send out information that this service is available. I think we ought to encourage and educate but not try to force this down anyone's throat.

Further discussion was held regarding these remarks and the Blues and also suggestion of the Chair that the matter be referred to Dr. Duke's subcommittee and to Blue Shield to investigate the possibility of establishing such a committee.

DR. GOSMAN: I make a motion that this Board of Trustees present a resolution at the next House of Delegates setting up a peer review committee and in the interim we go out on an education program. Seconded by Dr. Santare.

DR. HILLIS: I would like to hear someone offer a substitute phrase for peer review.

There was discussion concerning substitute phraseology. Dr. Petrich, the chairman, asked if the term "Medical Review Committee" would be acceptable.

CHAIRMAN: It is acceptable. It is accepted as an editorial change, Dr. Hillis. Is there any other question? The motion was put to vote and carried.

Economic and Organization Matters

DR. STEEN: Dr. Ferry, as chairman of the Convention Arrangements Commission, said that their commission had given some serious consideration as to what type of entertainment they ought to have for the annual convention. I suggested to John that it has been a number of years since we have had a Gaslight Party and they always went over pretty big and that maybe we ought to have another one. Somehow or other in the minutes, this recommendation did not come out strong, it was rather watered down, but I would like to recommend to the Board that the Board direct the Convention Arrangements Commission to arrange for a Gaslight Party.

CHAIRMAN: Motion is made by Dr. Steen and seconded pertaining to the Gaslight Party.

DR. STEEN: May I add that much of the cost of this party will be defrayed by the tickets which are sold to attend it.

CHAIRMAN: Is there any discussion? **The question followed and without opposition the motion was adopted.**

The Board then went into executive session.

EXECUTIVE COMMITTEE

April 11, 1970

The Executive Committee of the Indiana State Medical Association was called to order at 8:00 a.m. at the Host of America Motel in Melbourne, Florida by President Steen in the absence of the chairman, Dr. Kerr, due to the illness of his daughter.

Roll call showed the following present: Burton E. Kintner, M.D.; Lowell Steen, M.D.; Malcolm O. Scamahorn, M.D.; Peter R. Petrich, M.D.; Lester H. Hoyt, M.D. and James A. Waggener.

MINUTES OF THE MEETING held February 6th were approved on motion of Dr. Petrich and taken by consent.

MEMBERSHIP REPORT was reviewed and adopted by consent.

Membership Report as of March 25, 1970:

Number of members as of Dec. 31, 1969	4,482
1970 members as of March 25, 1970:	
Full dues paying	3,721
Residents and interns	68
Board remitted	43
Senior	349
Honorary	3
Military	35
Total 1970 members as of March 25, 1970	4,219
Total 1969 members as of March 31, 1969	4,314
Number of AMA members as of Dec. 31, 1969	4,330
1970 AMA members as of March 25, 1970	3,573—full dues paying
Number who have paid state dues but not AMA dues as of March 25, 1970	148
Number who paid state dues but not AMA dues as of Dec. 31, 1969	152

Headquarters Office

EMPLOYEES RETIREMENT PLAN—The secretary reported that under Federal law the employees retirement plan would have to be modified no later that January 1, 1971, to conform to new federal regulations. On motion of Dr. Kintner and taken by consent, the proposal by the Howard Nyhart Company, on the proposed changes, is to be referred to the Board Committee on Fiscal Matters.

HOOSIER TEEN HEALTH HAPPENING—The secretary reported on plans for the Hoosier Teen Health Happening and called attention to the $5000 donation by Eli Lilly. By consent, the secretary is requested to write a letter of appropriate thanks to Eli Lilly Company.

SUGGESTION OF DR. M.E. GLOCK that the Auxiliary Room in the headquarters building be named as the Ethel Gastineau Memorial Room, was reviewed and by consent this matter is to be referred to the Board of Trustees with the suggestion that an appropriate committee be appointed to study this matter and also to consult with the auxiliary as to whether they would favor the idea.

REPORT ON CERTIFICATION FORM—The secretary reported that a majority of the Board had voted favorably on the certification form for use in the Title XIX program.

IAGP REQUEST—On motion of Dr. Scamahorn and taken by consent, the Indiana Academy of General Practice was authorized to use the mailing list for notifying physicians of their annual meeting.

RUSSIAN TOUR OFFER—A proposal for the ISMA to sponsor a tour to Russia was reviewed and by consent this matter is to be referred to the Board of Trustees with the recommendation that the association not sponsor such a tour and to also recommend to the Board that county societies sponsoring tours should make it clear that such a tour is being sponsored by the county society and delete any reference to the ISMA.

Treasurer's Office

THE TREASURER REPORTED on the income and expenses for February and March; the cash and securities report and the investments. On motion of Drs. Hoyt and Petrich, the report was approved.

Organization Matters

DR. LLOYD HILL LETTER—A letter from Dr. Lloyd Hill addressed to the officers and trustees of the association was read for the information of the committee.

SECTION ON COLLEGE MEDICINE—A letter from Dr. J.M. Miller concerning the formation of the Section on College Health Physicians was reviewed for the information of the committee.

DELAWARE-BLACKFORD CO. MEDICAL SOCIETY LETTER—A letter from the Delaware-Blackford County Medical Society concerning their opinion on the Himler Report was referred to the Board of Trustees for their information.

LETTER FROM EUGENE M. GILLUM, M.D. was read for the information of the committee and the committee was informed that this had been handled by the chairman of the Board of Trustees.

RENEWAL OF MEMBERSHIP IN U.S. CHAMBER OF COMMERCE in the amount of $50 was approved on motion of Drs. Petrich and Kintner.

ACTIONS OF BLUE SHIELD BOARD—Several excerpts from the minutes of the Executive Committee and the Board of Directors of Mutual Medical Insurance were reviewed for the information of the committee.

CORRESPONDENCE TO DR. STEEN FROM DR. KIEFER—Correspondence from C. Raymond Kiefer, M.D. to the president of the association was reviewed for the information of the committee.

INDIANA HEALTH CAREERS—The matter of contributions to Indiana Health Careers was reviewed as was the previous action of the 1967 House of Delegates with respect to contributions to this organization. By consent this is to be referred to the Inter-Professional Relations Commission as well as the Board Committee on Fiscal Matters and to be discussed at the time of the preparation of the next budget of the association. It was further suggested that perhaps the Board might formulate a resolution to be presented to the House of Delegates relative to this matter.

LETTER TO HON. RICHARD RISTINE—A letter from the president addressed to the Hon. Richard O. Ristine, chairman of the Legislation and State Relations Committee of the Mental Health Association of Indiana was reviewed for the information of the committee.

REPLY FROM HEW—A reply to Dr. Steen's letter to the Department of HEW was reviewed for the information of the committee.

IHA JOINT MEETING—The preliminary outline for the joint meeting of chiefs of staff, administrators, and trustees of Indiana hospitals was reviewed and by consent the program outline was approved.

LETTER FROM AMA-COUNCIL ON MEDICAL SERVICE—A letter from the AMA transmitting a report from the AMA Council on Medical Services and listing three recommendations to be implemented by state and county societies with respect to P.L. 89-239, P.L. 89-749, and P.L. 90-174 were reviewed for the information of the committee.

LEE HAMILTON LETTER—A letter from Congressman Lee Hamilton concerning the association's letter voicing objection to the Senate Finance Committee report, together with a copy of a letter addressed to Congressman Hamilton by Russell Long, chairman of the Senate Finance Committee, were reviewed for the information of the committee.

LETTER FROM DR. FRANK GREEN—A letter from Dr. Frank Green addressed to the AMA citing certain portions of

the Himler Report was reviewed for the information of the committee and the secretary was requested to send copies of this comment to each member of the Executive Committee.

LETTER FROM DR. FELIX MILLAN—A letter addressed to the AMA from Dr. Felix Millan was read for the information of the committee.

LOUIS HARRIS SURVEY—A survey being conducted by the Louis Harris organization was reviewed by the committee and by consent this is to be referred to the Board of Trustees for their information.

LETTER ON AMA HEALTH MANPOWER—A letter from the AMA Department of Health Manpower was reviewed for the information of the committee.

PENNSYLVANIA GRADUATE SCHOOL SURVEY—A copy of a survey being planned by the Graduate School of Public Health, University of Pittsburgh, was reviewed for the information of the committee.

REGIONAL ADVERTISING PROGRAM BLUE SHIELD—The matter of the Regional Advertising program proposed by the Blue Shield Regional Program Conference, together with a report of an experiment to be conducted by the Cincinnati Blue Cross Plan were reviewed for the information of the committee.

ANNOUNCEMENT FROM THE MICHIGAN STATE MEDICAL SOCIETY that they proposed to nominate Otto K. Engelke, M.D., for the office of vice president of the AMA and that they proposed the nomination of Dr. John W. Moses for a seat on the AMA Council on Medical Education were reviewed for the information of the committee.

BALL MEMORIAL HOSPITAL STAFF MATTER—A staff matter concerning the staff of Ball Memorial Hospital and their action was reviewed for the information of the committee.

LETTER FROM VANDERBURGH COUNTY SOCIETY concerning a request from their local Red Cross Chapter was referred to Dr. Farquhar's Commission on Emergency Medical Services for their opinion.

Legal Matters

STATEMENT FROM ATTORNEYS for services rendered was approved for payment by consent.

OPINION ON MEDICAID—An opinion of the attorney concerning the Medicaid law was reviewed for the information of the committee and the secretary is requested to make copies for each member of the Executive Committee.

STATEMENT FOR DEFENSE OF A PHYSICIAN—A statement from the attorneys in defense of a physician was approved for payment on motion of Drs. Petrich and Hoyt.

OPINION COMMISSION ON VOLUNTARY HEALTH AGENCIES—Several matters from the Commission on Voluntary Health Agencies by consent were referred to the Board of Trustees.

LETTER CONCERNING THE OPTOMETRIC LAW—A letter from a physician concerning the Optometric Law was reviewed and Dr. Offutt is to be requested to obtain an opinion from the attorney general.

BLOOD DECISION—A letter regarding the decision of a court concerning their ruling that the transfusion of blood was considered a sale and not a service was reviewed for the information of the committee.

LETTER REGARDING FOURTH HOSPITAL IN FORT WAYNE—A copy of correspondence between the Indiana Hospital Association and the hospital administrators of Fort Wayne concerning the possible establishment of a fourth hospital in Fort Wayne was reviewed for the information of the committee.

ENURETIC CONDITIONING PROGRAMS—A questionnaire submitted to the association concerning Enuretic Conditioning Programs was reviewed and the answers were prepared for submission to Denver.

The Journal

REQUEST FROM SMJAB—A request of the State Journal Advertising Bureau concerning the acceptance of laboratory advertising was reviewed and *The Journal* will not accept any clinical advertising on motion duly made and taken by consent.

Future Meetings

The 23rd RURAL HEALTH CONFERENCE to held in Milwaukee April 9-10—no representative will be sent.

INVITATION TO THE INTERSTATE COMPACT ON MENTAL HEALTH meeting in San Francisco, May 10th—no representative will be sent.

SEMINAR ON FOUNDATIONS FOR MEDICAL CARE to be held in Palm Springs, California, May 21-24—the president was authorized to name a representative if he felt this was worthwhile.

WATER POLLUTION CONFERENCE to be held in Toronto April 16-17—no representative is to be sent.

There being no further business, the committee adjourned to meet again upon call of the chairman.

EXECUTIVE COMMITTEE

May 18, 1970

The meeting was called to order at 4:30 p.m. in the headquarters office by Donald M. Kerr, chairman.

Present: Donald M. Kerr, M.D., chairman; Burton E. Kintner, M.D.; Lowell H. Steen, M.D.; Malcolm O. Scamahorn, M.D.; Peter R. Petrich, M.D.; Lester H. Hoyt, M.D.; Frank B. Ramsey, M.D.; and James A. Waggener.

MINUTES OF THE MEETING held April 11, 1970 were approved on motion of Drs. Steen and Scamahorn.

MEMBERSHIP REPORT as of April 30, 1970 was reviewed, discussed and adopted by consent.

Membership Report as of April 30, 1970:

Number of members as of December 31, 1969	4,482
1970 members as of April 30, 1970:	
Full dues paying	3,875
Residents and interns	76
Board remitted	54
Senior	352
Honorary	3
Military	39
Total 1970 members as of April 30, 1970	4,399
Total 1969 members as of April 30, 1969	4,390
Number of AMA members as of Dec. 31, 1969	4,330
Number of AMA members as of April 30, 1970	4,227—full dues paying
Number who have paid state dues but not AMA dues as of April 30, 1970	169
Number who paid state dues but not AMA dues as of Dec. 31, 1969	152

Treasurer's Office

The statement on income and expenses for the month of April, cash and securities report, and investments were reported by the treasurer and the report was approved on motion of Drs. Hoyt and Steen.

Organization Matters

LETTER FROM DR. OFFUTT TO DR. STEEN—Dr. Steen discussed a letter he had recieved from Dr. Offutt and the discussion he had had with several representatives involved in the Regional Medical Program. By consent it was agreed that with the permission of Dr. Offutt, this letter be distributed to the Board of Trustees and copies sent to the AMA.

The president also reported on his meeting with representatives of the state

RMP program in which he explored the possibility of a grant from RMP for the purpose of expanding the field service of the association by the addition of two additional field men to be solely under the direction of the ISMA and the field men would serve a dual purpose as informants on the RMP program as well as the regular duties of the association. By consent it was agreed that this matter should be explored further.

LETTER FROM DR. BLAZEY—A letter from Dr. Blazey thanking the association for the certificate acknowledging his service to the association was read for the information of the committee.

LETTER FROM DR. W.H. HOWARD—A letter from Mrs. W.H. Howard also expressing appreciation on behalf of Dr. Howard for his certificate was read for the information of the committee.

LETTER FROM INDIANAPOLIS PHYSICIAN—A letter from an Indianapolis physician requesting an extension of time for payment of dues was read and the secretary announced he had referred this to the Marion County Medical Society.

MECO PROJECT—A letter from the Illinois State Medical Society concerning the MECO project conducted by SAMA was read and on motion of Drs. Scamahorn and Steen this matter is to be referred to the Commission on Medical Education and Licensure.

HEALTH CAREERS MATTER—The secretary requested a clarification on the previous action taken to expend $50.00 to Health Careers, Inc., and by consent, the secretary is instructed to send the $50.00.

LETTER FROM BOARD OF HEALTH—A letter from the State Board of Health concerning recommendation from the Bureau of Health Insurance concerning areawide utilization review committees was read for the information of the committee and no action taken.

DR. STEEN'S LETTER TO DR. MANNING—Dr. Steen reported on correspondence he had had with Dr. Manning concerning the Blue Shield membership cards using the phraseology "present this card to the providers of service." The correspondence dealt with changing this "to your physician."

DR. STEEN'S LETTER TO MR. STERRETT—The president reported on an exchange of correspondence he had had with Mr. Sterrett, the administrator of the Department of Public Welfare, concerning requirement of intermediate care facilities certification under Title XIX of the Medicare Act.

BLUE SHIELD MATTERS—Several matters dealing with the actions of the Blue Shield Board of Directors and materials distributed to physician's assistants were reviewed for the information of the committee.

LETTER FROM AMA TO AN INDIANA PHYSICIAN—Concerning the problem of joining a county medical society and the recommendation by the AMA General Counsel were reviewed for the information of the committee.

RESOLUTION FROM DELAWARE-BLACKFORD SOCIETY—A resolution from the Delaware-Blackford Medical Society concerning the Governor's Commission on Medical Education was read and by consent it is to be forwarded to the House of Delegates meeting in October.

COMMENTS ON HIMLER REPORT—The secretary reported he was unable to reproduce satisfactorily the marginal comments on the Himler Report made by Dr. Anderson, an English physician, and sent to Dr. Frank Green for comparison to copies of the Himler Report.

LETTER FROM DR. CAMERON—A letter from Dr. Don F. Cameron thanking the association for his certificate for past service was read for the information of the committee.

LOUIS HARRIS SURVEY—The secretary reported he was unable to satisfactorily reproduce copies of the Lou Harris survey which was previously directed by this committee and the chairman of the Board is going to attempt to reproduce this material for the members of the Board.

LETTER FROM INDIANA NURSING HOME ASSOCIATION—A letter from the Indiana Nursing Home Association stating that they would like to use the association mailing list for distribution of a new official publication of the Indiana Nursing Home Association was read and the request was approved on motion of Drs. Steen and Kintner.

LETTER FROM DR. DAN T. MILLER—A letter from Dr. Dan Tucker Miller addressed to the president concerning the president's letter distributed to the membership on April 7th was read and on motion of Drs. Petrich and Steen, publication of this letter in *The Journal* was recommended.

FAMILY SERVICE ASSOCIATION MEMBERSHIP—A request for a contribution for the Family Service Association was reviewed and by consent no donation will be made.

ACR BULLETIN—A copy of a letter written by Mr. Thomas Tierney, director of the Bureau of Health Insurance, SSA, and addressed to the American College of Radiology, was reviewed for the information of the committee.

TEEN HEALTH WEEK—The president reported on the Teen Health Week program and labeled it as one of the best public relations efforts made by the physicians of Indiana in working with the public and the youth of this state.

REPORT ON CONFERENCES HEW AND RMP—The president then reported on his and the executive secretary's meeting with the officials of the regional offices of HEW and reported that the officials were listing the Indiana Department of Welfare as being in non-compliance by not having a statement concerning fraud on the claim blanks used by physicians to file for services under Title XVIII and Title XIX. The secretary reported that under the Principles of Ethics, a member of the association could not engage in fraud and therefore claimed that a letter to this effect would preclude the insertion of such a statement on claim forms. His suggestion was accepted.

COMPLAINTS AGAINST BLUE SHIELD—Dr. Petrich then discussed the matter of complaints against Blue Shield for unpaid services by Indiana physicians and felt that a special committee should be established to handle these complaints.

Following a lengthy discussion of this matter, on motion of Drs. Steen and Scamahorn, it was moved that all complaints be referred to the Commission on Governmental Medical Services and that the commission be requested to file a report concerning their findings on these complaints with the Board of Trustees at their June meeting.

Convention Matters

The secretary asked for instructions as to the special guests to be invited to the 1970 annual meeting and reviewed the previous guest list. On motion of Drs. Petrich and Scamahorn the same group is to be invited for the 1970 meeting as was invited to the 1969 meeting with the seating of the guests to be left to the discretion of the president.

On motion of Drs. Steen and Kintner, the president of the West Virginia Medical Society is to be added to the invitational list.

50-YEAR CLUB—The secretary then requested direction as to the person to be selected to give the response on behalf of the 50-Year Club and read the list of those being taken into the club at the 1970 meeting. He also read a letter from the Fort Wayne Medical Society announcing a recommendation of a Fort Wayne physician to do this. Following discussion, and by consent, it was voted to request Dr. Roy V. Myers to make this response.

TRUSTEE MEETINGS—By consent it was decided that breakfast meetings of the trustees would be held each morning during the annual session in October.

HONORARIUMS—The secretary asked for clarification of the policy regarding payment of honorariums to section and general session speakers. By consent, the secretary was instructed that a speaker appearing on a general program and also on a section program on the same day would only be paid one honorarium.

Legal Matters

OPINION ON M.D. TESTIFYING—An opinion of the legal counsel concerning physicians on a review committee of a county society testifying in court cases was approved for payment by consent and the opinion was expressed that this opinion should be reproduced in *The Journal* for the benefit of all members.

OPINION TO ST. JOSEPH COUNTY SOCIETY—A letter to a county society from legal counsel concerning the changes in their Constitution and Bylaws designed to censor or suspend incompetent physicians was reviewed for the information of the committee.

New Business

CANDIDATES FOR AMA OFFICE—The secretary read letters from the Delaware, Nevada, Ohio, New Mexico and Michigan state societies concerning candidates whom they expected to nominate for office in the American Medical Association at its annual meeting in June, 1970.

INTERFAITH PRAYER BREAKFAST AMA—The secretary read a letter from the AMA concerning a new feature at the annual meeting which will be instituted this year, an Interfaith Prayer Breakfast to be held Sunday morning, June 21st. This was taken as a matter of information.

UTILIZATION OF PARAMEDICAL PERSONNEL—A letter from the secretary to the medical staff of an Indiana hospital concerning the legality of utilization of paramedical or ancillary personnel, as applied to hospital practice, was reviewed and by consent it was agreed that the secretary should try to obtain specific questions that they might have concerning this type of personnel.

Future Meetings

Attention was called to the annual meeting of the AMA beginning June 21 in Chicago and also a letter from the AMA inviting representation in the Legal Conference on September 18th in Chicago and the Third Congress on Medical Ethics on September 19-20 in Chicago. On motion of Drs. Petrich and Steen, the executive secretary was named to represent the association.

There being no further business the committee adjourned to meet again at 12:00 Noon on Saturday, June 13, in the headquarters building.

Excellent New Anti-Chiropractic Book Recommended by the AMA

"At Your Own Risk: The Case Against Chiropractic" is the title of the book, authored by Ralph Lee Smith, published recently by Trident Press.

It is of particular value to the medical profession in that the debunking of chiropractic as a "science" is a factual, fully documented presentation of the history, philosophy and present-day practices of a profession that has confused the public by its false aura of science and its achievement of state licensure.

In a letter to each society, H. Doyl Taylor, director of the department, announced that although the hard-covers are priced at $4.95, the special reduced cost for 11 or more is only $2.50 each.

Similarly, the individual price for the paperbacks is 95¢, but the AMA is making a special offer of 50¢ each for orders of 11 or more. The books, in both hard-cover and paperback, are available from the AMA Order Department, 535 North Dearborn Street, Chicago, Ill. 60610.

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Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

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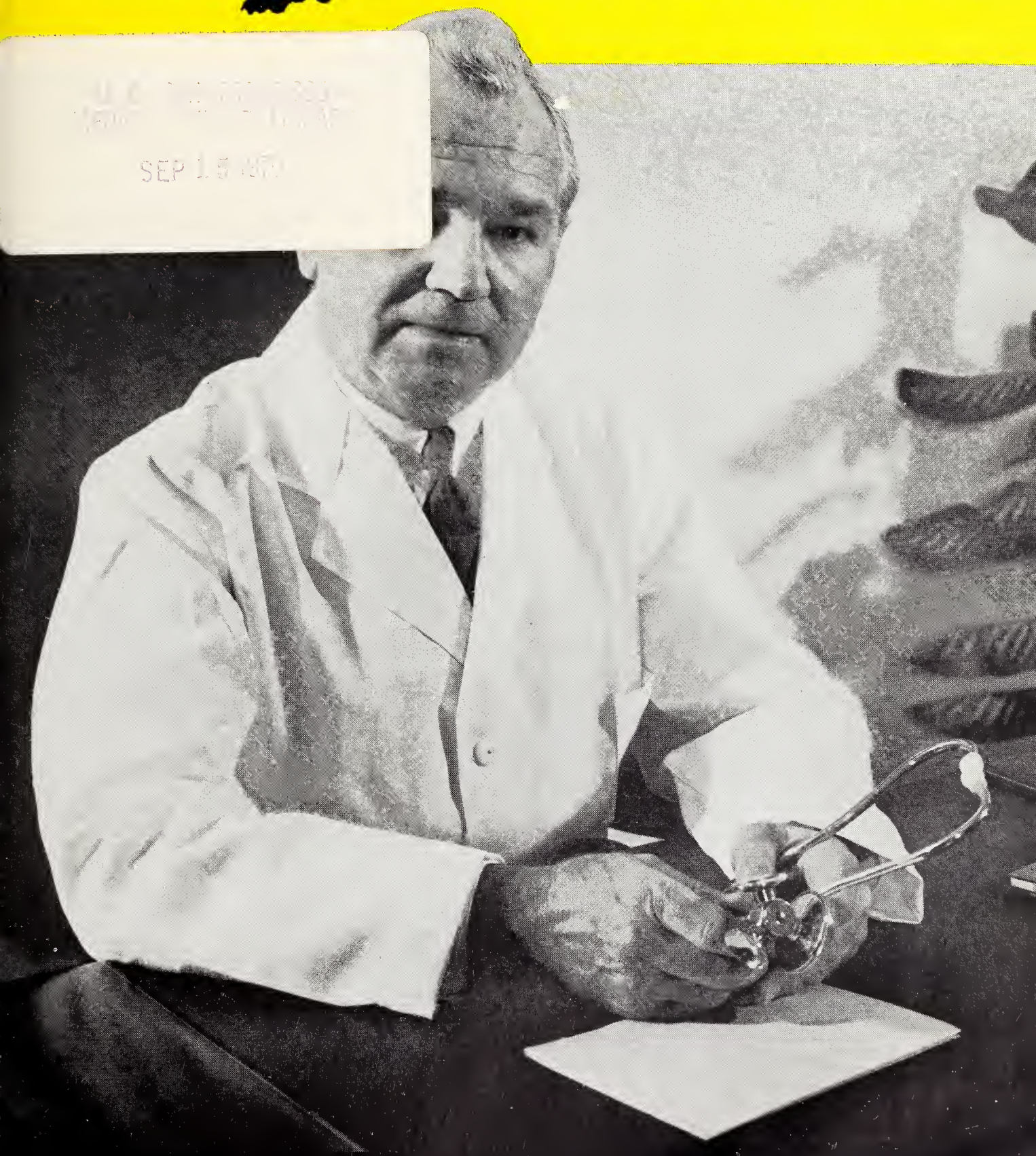
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The JOURNAL

Indianapolis, Indiana

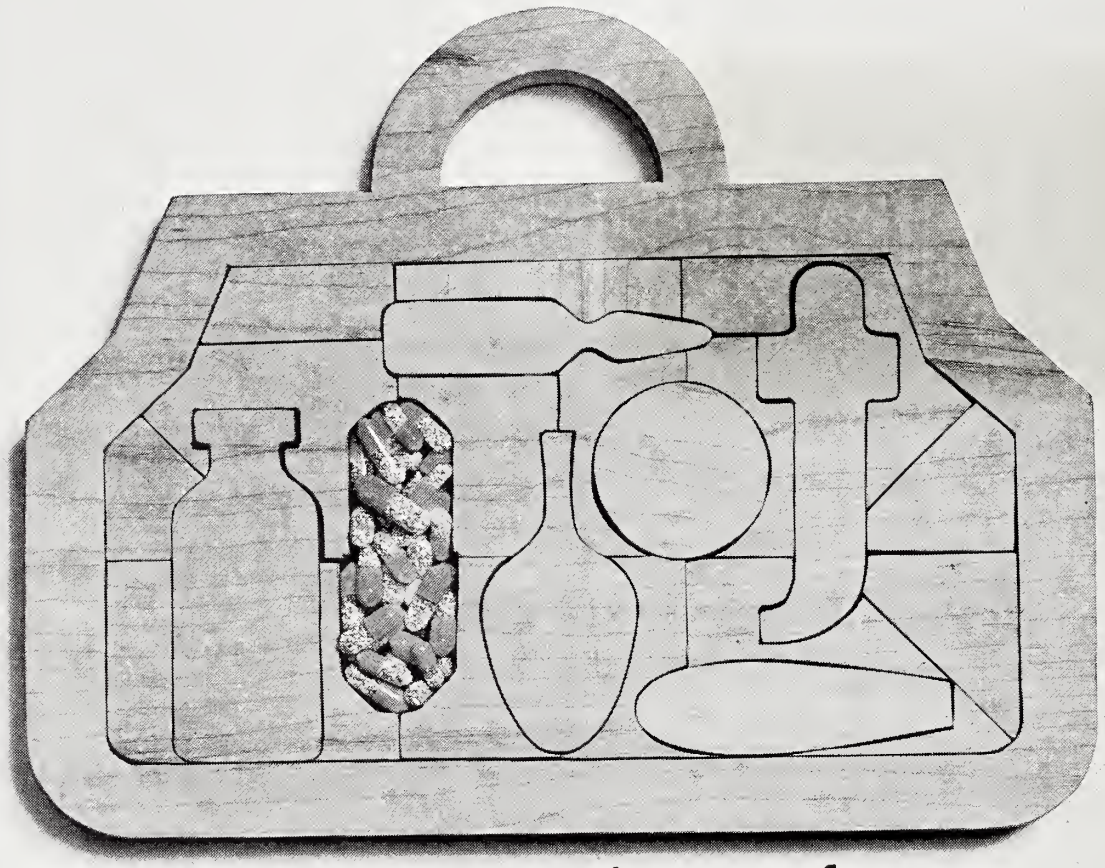
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August, 1970
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All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 46202. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

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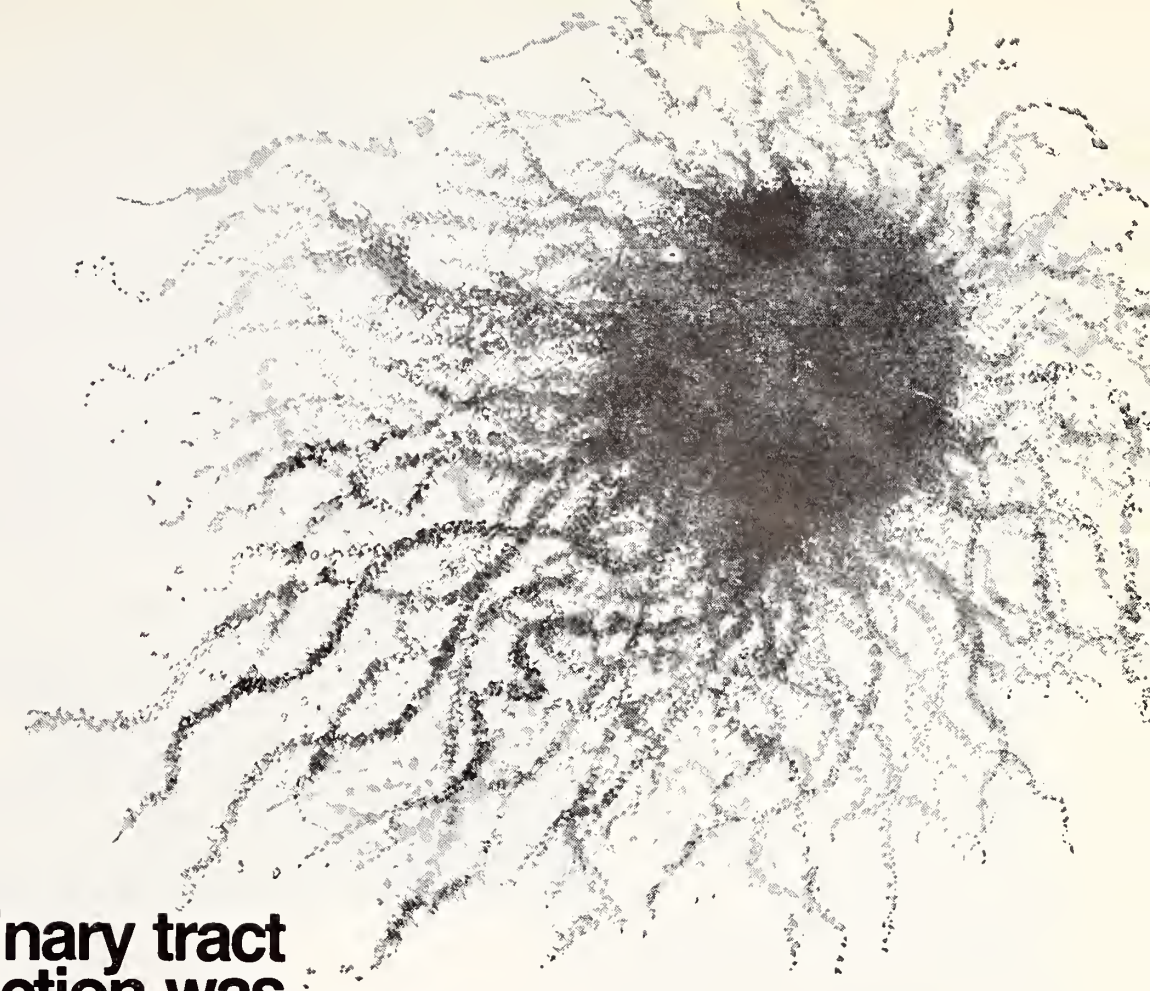
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4—Robert M. Reid, Columbus	Oct. 1971
5—Wilbert McIntosh, Riley	Oct. 1972
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7—Dwight W. Schuster, Indianapolis	Oct. 1972
8—Richard Ingram, Montpelier	Oct. 1972
9—Peter R. Petrich, Attica (Chairman)	Oct. 1970
10—Vincent J. Santare, Munster	Oct. 1971
11—Lowell Hillis, Logansport	Oct. 1972
12—William R. Clark, Fort Wayne	Oct. 1970
13—Otis R. Bowen, Bremen	Oct. 1971

ALTERNATES

District	Term Expires
1—Eugene Austin, Evansville	1970
2—Betty Dukes, Dugger	1971
3—Elmer L. Wallace, New Albany	1971
4—Jack E. Shields, Brownstown	1970
5—Cleon M. Schauwecker, Greencastle	1970
6—Paul M. Inlow, Shelbyville	1972
7—John O. Butler, Indianapolis	1972
7—Joseph C. Kerlin, Danville	1972
8—Paul Sparks, Winchester	1970
9—Lindley Wagner, Lafayette	1971
10—Thomas C. Tyrrell, Hammond	1972
11—James A. Harshman, Kokomo	1971
12—Frederic L. Schoen, Fort Wayne	1971
13—G. Beach Gattman, Elkhart	1970

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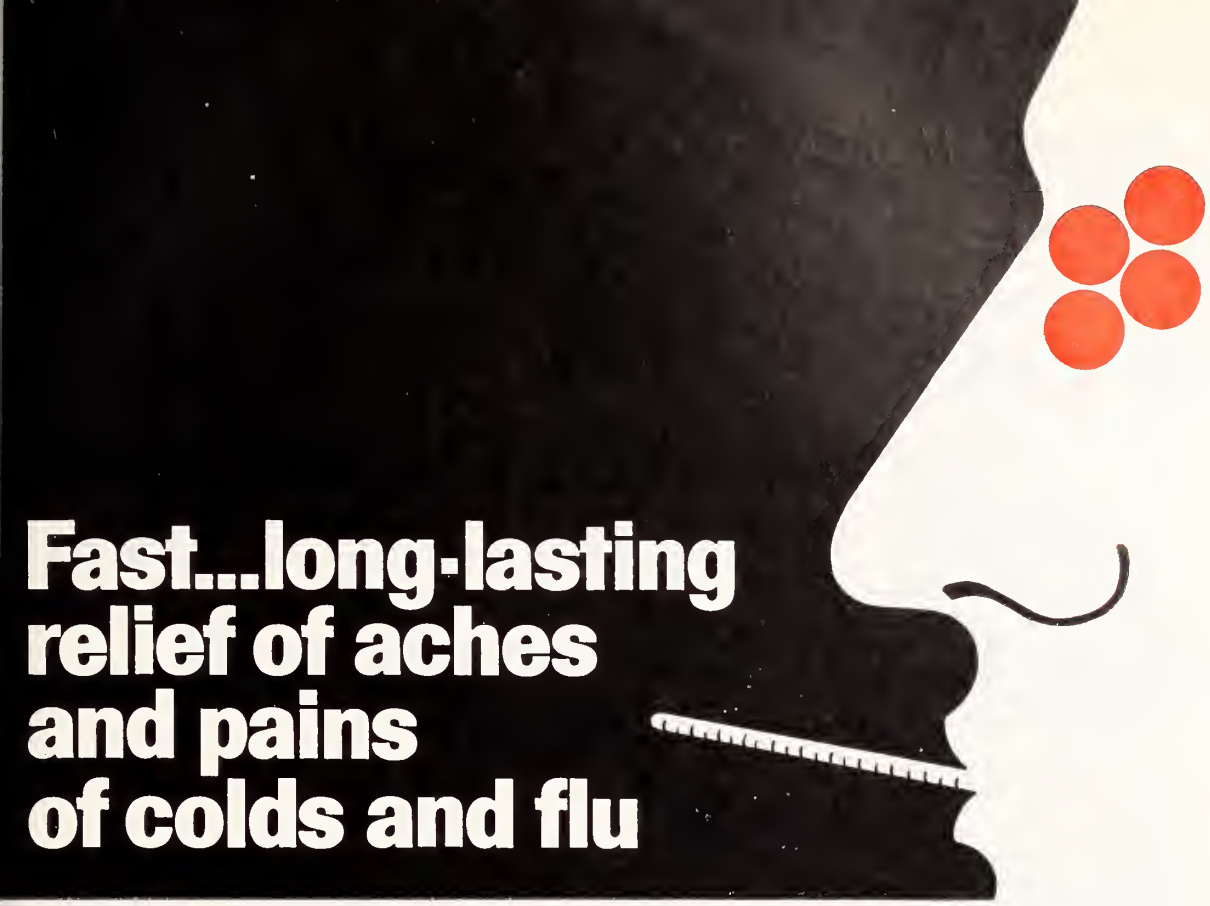
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Frank H. Green, Rushville	Kenneth O. Neumann, Lafayette

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John Farquhar, Fort Wayne	Thomas C. Tyrrell, Hammond

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3.	Daniel H. Cannon, New Albany	Elmer L. Wallace, New Albany	
4.	Gordon S. Fessler, Rising Sun	Fred D. Houston, Lawrenceburg	
5.	William G. Bannon, Terre Haute	James W. Cristee, Terre Haute	
6.	David Wynegar, Richmond	John Moenning, Greenfield	May 5, 1971, Greenfield
7.	Ellery T. Drake, Martinsville	Donald E. Stephens, Indianapolis	
8.	Eugene M. Gillum, Portland	Ralph E. Schenck, Portland	June 2, 1971, Portland
9.	James M. Kirtley, Crawfordsville	Wesley E. Shannon, Crawfordsville	
10.	Robert Milos, Gary	J. M. Siekierski, Griffith	
11.	Julius T. Steffen, Wabash	Fred Poehler, La Fontaine	Sept. 23, 1970, Marion
12.	George C. Manning, Fort Wayne	William B. Hughes, Waterloo	May 19, 1971, Fort Wayne
13.	James D. Finfrock, Elkhart	John Hildebrand, South Bend	Sept. 3, 1970, Elkhart



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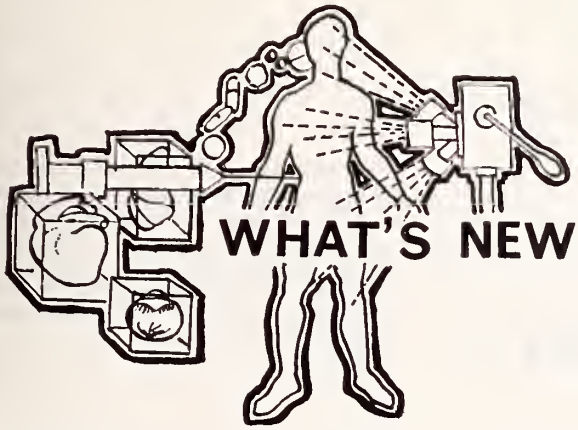
One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contoins: Quinine sulfote, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those assaciated with orthritis, diabetes, varicose veins, thrambaphlebitis, arteriasclerasis ond static faot defarmities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps In some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastraintestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, ar visual disturbances accur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased ta ane tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps



Haemo-Sol has a new cleaner designed especially for dried-on blood stains and other difficult-to-remove soil from medical and similar equipment. It is called HAEMO-SOL® E.A. It is enzyme active and one-half hour of soaking is sufficient to loosen blood and stains. Free samples are available from Haemo-Sol, Box 6882, Baltimore 21204.

* * *

Parke Davis announces a new blood plasma substance called Albuspan. It is composed of normal human serum albumin in either five percent solution or 25% solution. The five percent solution is marketed in either a 250-cc bottle or a 500-cc bottle. The 25% solution comes in a 20-cc bottle or a 50-cc bottle.

* * *

Travenol Laboratories announce a new Triflex™ disposable examination glove. The gloves are made of durable vinyl and are available in sterile or non-sterile form. They are packaged singly or in pairs, or in plastic wall dispensers — 50 gloves to the box.

* * *

Upjohn has a new prescription package for the patient on alternate day steroid therapy. Called the Medrol 16 mg Alternate Daypack, the package contains fourteen 16 mg scored tablets sealed in alternate calendar day positions. Clinical trials have shown that doses taken at the same time of day and repeated 48 hours later and so forth are most effective. The "day-off" probably decreases the incidence and degree of adrenal suppression.

* * *

Carlton Press, 84 Fifth Avenue, New York City, has just released a book "Charity Versus Character" by Dr. M. H. Mothersill of Indianapolis. It is described as "a sobering discussion of America's current crisis."

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

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To bring effective calcium therapy to the patient, Calphosan may be administered intramuscularly . . . without pain, inflammatory reactions, induration or sloughing. Injections twice weekly for a series of 5 to 10 injections are recommended.

Average dose per injection: One or two 10 ml. injections of Calphosan each week for the first four or five weeks, and on a when-needed basis thereafter.

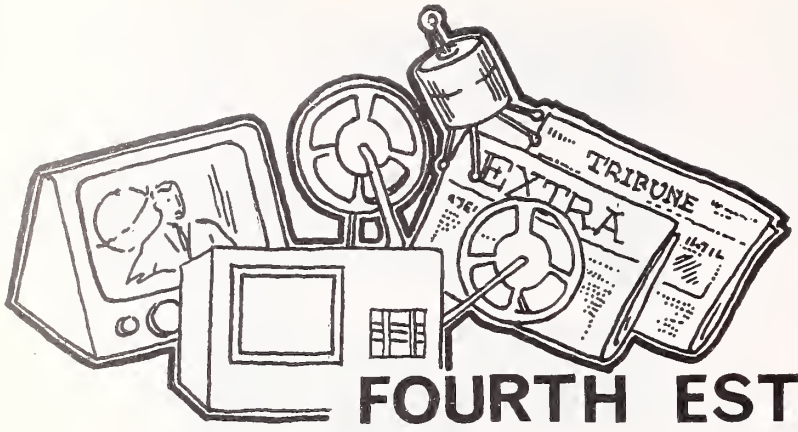
Calphosan is a specially processed solution of calcium glycerophosphate and calcium lactate, containing 1% of each, in a physiological solution of sodium chloride. Each 10 ml. contains 50 mg. of calcium glycerophosphate, 50 mg. calcium lactate, with 0.25% phenol as preservative. Available in 10 ml. ampules in boxes of 10s and 100s; 60 ml. multiple-dose vials. Also available as Calphosan with B-12. U. S. Patent No. 2657172.

Contraindication: Hypercalcemia; neoplastic diseases; and fully digitalized patients. Do not use intramuscularly in infants and young children. Before starting therapy, consult complete product literature.

Write for free copy of "Calcium: The Ubiquitous and Essential Element" and for samples.

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FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Drug Substitution

The decision by the House of Delegates of the American Pharmaceutical Assn. to seek repeal of "antisubstitution" drug laws and regulations (AMN, April 27, 1970) is a step backward.

If successful, the APhA efforts could lead to a situation which would permit a pharmacist who chose to do so to dispense a substitute in defiance of the physician's best therapeutic judgment, without the physician knowing when a substitute was dispensed or what it was. Clearly, such a step is not in the best interest of the individual with the most of stake: the patient.

The APhA had worked successfully for enactment of the antisubstitution requirements in the 1950s, with such success that today, only Alaska, Missouri, and the District of Columbia permit brand-name substitution by pharmacists.

Today, however, the APhA feels that changing conditions necessitate repeal. For example, it contends that in some states, when a physician prescribes for a welfare patient a drug not listed in the state-approved formulary, or costing more than the maximum allowed, the pharmacist must refuse to dispense the medication; or charge the state only the allowable amount; or violate the antisubstitution law and dispense a cheaper drug.

Furthermore, some pharmacists assert that their training makes them competent to decide about substitutions without consulting the physician.

However, it should be remembered that when the antisubstitution laws were written, they were aimed at curbing the unethical practice of pharmacy. Furthermore, that is *still* the effect of these laws; the ethical pharmacist is in no way restricted.

The physician who wishes to delegate product selection to a trusted pharmacist has three choices: prescribing generically, prescribing by brand "or equivalent," or including a statement permitting substitution on the prescription.

Under this arrangement, the physician may consult the pharmacist about price and availability of quality generics, make alternate choices of branded products, or subscribe to use of products listed in a hospital formulary system. The pharmacist, in turn, is free to consult with the M.D. about his prescription, and to suggest alternate products.

Generic equivalency—widely proclaimed by some as the ultimate answer to prescription costs—has been shown by many scientists, including members of the pharmaceutical profession, often to be a myth. Some of this research has revealed that biological differences in supposedly equivalent drugs could alter the efficacy of the M.D.'s prescribed therapy.

Despite these facts, a majority of members of the APhA House of Delegates voted to seek the removal of the present antisubstitutions bans.

Since state laws and regulations are involved, physicians can expect a state-by-state campaign for repeal by organized pharmacy. Medicine must be prepared to mount equally vigorous campaigns.—*American Medical News*, May 4, 1970.

Emergency Room Service

Credit the Porter Memorial Hospital trustees, its medical staff and Administrator Arthur Malasto for culminating plans for full-time emergency room coverage.

It's a step in the right direction at a hospital where streamlining of departments is becoming more and more a necessity.

Effective July 1, Dr. Martin J. O'Neill and his group known as Associated Physicians, Inc., will provide round-the-clock coverage for emergency room patients who don't have doctors available and are in dire need of immediate emergency treatment.

Therefore, no longer, after July 1, will emergency room patients be subjected to unnecessary waiting periods while the "on-call" doctor for the day is being located.

Three doctors will initially be on round-the-clock duty, with a fourth also available prior to his becoming a member of the nation's Armed Forces.

The new service will tend to provide relief to other city and county physicians, who on many occasions were forced to leave office practice to treat emergency patients brought to Porter Memorial.

In addition, according to Malasto, the service should result in attracting new doctors to Porter county.

The general public should be reminded that the private group of doctors taking over the emergency room "will not admit patients to Porter Memorial." Admissions will be handled through a roster of physicians provided by the hospital's medical staff.

In addition, the public is reminded that routine medical illnesses, normally handled in a doctor's office, "will not be handled by the emergency room physicians." These doctors are there to provide treatment to emergency patients whose family doctor is not immediately available for service.

It is a much-needed service and one which will result in facilitating movement of patients in a department which has become one of the busiest in the hospital.

Everyone concerned with the culmination of this plan, should be commended for bringing to Porter Memorial another advancement in providing on-the-spot, life-saving treatment in time of emergency.—*Valparaiso Vidette-Messenger*, June 4, 1970.

New M.D.'s Welcome

Within weeks 8,500 new physicians will receive their M.D. degrees. They will be a welcome addition to one of the most demanding professions a young man or woman can choose.

From their initial assignments as interns throughout their careers these 8,500 new physicians will be constantly impressed by the fact there is an inadequate number of them to care for the waiting workload. The demand for interns this year exceeds the number of new doctors by more than 50%.

That has become an old story in the medical profession, and certainly one which must be listed as a prime cause of staff shortages and rapidly rising medical costs. The 1970 graduating class is 20% larger than the 1960 class, but in those 10 years the demand for their services has increased several fold.

Medical schools are expanding and new ones are starting up, but at a pace far slower than required. This is one profession which cannot be turned off or on by sketchy campaigns. It requires great sums of money, vastly more trained personnel than now are available and years of training to achieve results.

Each year it becomes more apparent that something more dramatic is needed — perhaps some type of intermediate training which can prepare thousands of professionals in a shorter time to relieve the M.D. from much of the routine work so he can practice his skills where they are needed most.—*Crawfordsville Journal & Review*, June 6, 1970.

A Positive Crime Fight Step

Lake County, with the tacit approval of 10 others, has taken a positive governmental step forward which could hopefully lead to others.

The Lake County Council has approved a resolution authorizing the setting up of a chemical toxicology laboratory under direction of the county coroner to serve the 11 counties of northwest Indiana.

The approval was not surprising. At the outset at least it will cost the county nothing. The program is expected to be financed in its beginning by federal grants and by Mercy Hospital. Involvement of the 10 other counties is because the 11 comprise Region I of the Indiana Criminal Justice Planning Agency.

Formal approval of that agency is the next step required. Informally, that approval has been indicated in advance by leaders of that agency's directorate and by Indiana State Police authorities. That, it is believed, should assure allocation of federal funds necessary to get the laboratory into operation.

The laboratory is part of a program conceived several years ago by Dr. Alexander Williams, the Lake County coroner. He won resolution support for the concept as a pilot program in the last legislature, but trying to wangle financial support was something else. That is why the new approach — relying on federal and private funds — was attempted.

The toxicology laboratory would be designed to analyze blood, tissue, urine and other such specimens to determine the possible presence of narcotics or alcohol in the event of deaths or injury. It could also analyze the contents of substances taken in raids and presumed to be narcotics. The necessity of such a program is sufficiently realized by law enforcement officers to have reportedly gained the support of all enforcement agencies in the 11-county area for the laboratory project.

The initial year's cost is estimated at some $218,000. Of that amount, some $130,000 would be for equipment and would not be a recurring expense. It is this amount for which federal financing is anticipated. Of the remainder, $44,000 would be for salaries of technical experts which would be financed for the first year at least by Mercy Hospital. The rest would be for consumable supplies, rent and refurbishing of a building adjacent to Mercy Hospital and already earmarked for the project.

Other financing would have to be arranged for the future for such ongoing expenses as salaries, rent and consumable supplies. Assuming the laboratory can show the worth most expect, that could come from county

Continued

and other local sources on a pro-rata basis.

It could hopefully lead to expansion into a full-fledged crime laboratory, including such other phases as photography, x-ray, ballistics and microanalysis. It could hopefully lead in time, too, to reorganization of coroner's offices, possibly on a regional basis, but as scientifically technical offices rather than political.

It still all has to be proved. First steps, though, at least are promising. —*Gary Post-Tribune*, June 11, 1970.

It Happens Right Here!

The 7-day period from May 24-30 was proclaimed Drug Abuse Prevention Week by President Nixon. Our local press failed to call our attention to it. Only one of Marion's radio stations devoted a program to it. Even the Grant County Drug Council neglected to publicize the President's call for cooperative ventures to communicate the potential dangers of drug experimentation. Our inertia has developed into a lethargical attitude which allows the drug problem to grow. It happens right here!

One of the relatively active GCDC members informed the authorities that his daughter had been offered marijuana. It happened right here!

The Indiana State Medical Assn. held the Hoosier Teen Health Happening on April 23 and 24 in Indianapolis. The event was nationly acclaimed and is scheduled to be repeated annually. According to participants' reports to the GCDC, "samples" were available at the 2-day conference, a further proof of the magnitude of the drug problem. It happened right here!

In his newsletter of May 14, our Fifth District Representative, the Honorable Richard L. Roudebush, called attention to the necessity of drug deterrent information. Our high school students who reported to the GCDC ventured the opinion that there was insufficient stress on deterrents at the Indianapolis convention. It happened right here!

The time has come for the authorities to change from an ostrich policy to action. What has happened right here, and is still happening, requires immediate remedial measures. We can teach the lesson that the human body and mind are capable to act at their fullest capacity without the "aid" of drugs of any kind. Only the sick and infirm require such "aids."

The healthy individual must be made aware that he will become unhealthy if he uses drugs. Hence, education is the deterrent available to us. Let's make use of it until we can say: it happened right here, but it happens no more, because we have learned the lesson that we can be ourselves only if we remain as drug-pure as the Creator has made us.—Stefan Ansbacher, Sc.D.—*The Farm News of Grant County*, Marion, June, 1970. ◀

Errata

The names of four full-dues paying members were inadvertently omitted from the June Roster issue of *The Journal*. We regret any embarrassment caused by the error. The names which should have appeared are:

William Renforth, M.D. (Fayette-Franklin) 612 Tulip Lane, Connersville 47331

William L. Myers, M.D. (Elkhart) R. R. 3, Syracuse 46567

William M. Cockrum, M.D. (Vanderburgh) 1001 Walnut St., Evansville 47713

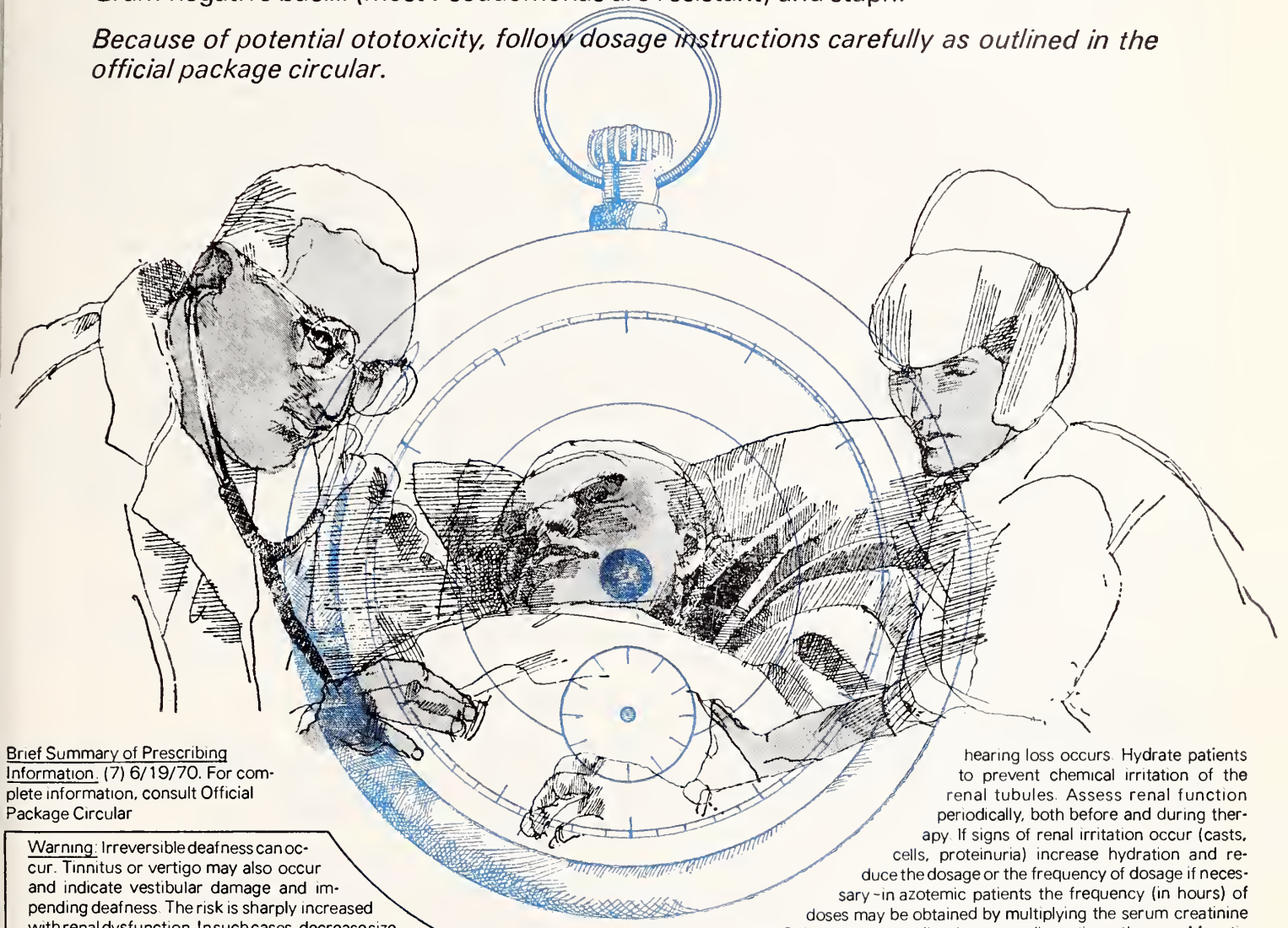
John D. Wilson, M.D. (Vanderburgh) 3700 Bellemeade, Evansville 47715

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in severe systemic infections—postoperative bacteremia, Gram-negative/staph pneumonias or neonatal sepsis—Kantrex® (kanamycin sulfate) is often indicated before results of customary sensitivity tests can be reported. Clinical response is often seen within 24-48 hours in susceptible infections, with remission soon after.

10 years of experience confirm the continuing effectiveness of Kantrex® against many Gram-negative bacilli (most Pseudomonas are resistant) and staph.

Because of potential ototoxicity, follow dosage instructions carefully as outlined in the official package circular.



Brief Summary of Prescribing Information (7) 6/19/70. For complete information, consult Official Package Circular

Warning: Irreversible deafness can occur. Tinnitus or vertigo may also occur and indicate vestibular damage and impending deafness. The risk is sharply increased with renal dysfunction. In such cases, decrease size and frequency of doses. Discontinue kanamycin and check hearing if azotemia increases. Watch carefully for ototoxicity in older patients and patients receiving more than 15 Gm. of kanamycin. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in post-operative patients until recovery from anesthesia and muscle relaxants is complete. Avoid concurrent use of other ototoxic drugs including ethacrynic acid. Safety in pregnancy is not established.

Indications: Serious infections due to susceptible strains of *E. coli*, Proteus sp., *A. aerogenes, K. pneumoniae, Serratia marcescens* and *Mima-Herellea*. Culture and sensitivity studies should be performed.

Contraindications: A history of hypersensitivity to the drug. Prior auditory damage by kanamycin or other agents may be a contraindication if effective alternative therapy is available.

Precautions: Obtain audiograms before and during therapy in patients with renal dysfunction when treatment lasts more than 5 days. Stop Kantrex if tinnitus or hearing loss occurs. Hydrate patients to prevent chemical irritation of the renal tubules. Assess renal function periodically, both before and during therapy. If signs of renal irritation occur (casts, cells, proteinuria) increase hydration and reduce the dosage or the frequency of dosage if necessary. In azotemic patients the frequency (in hours) of doses may be obtained by multiplying the serum creatinine by 9. If azotemia or oliguria occur, discontinue therapy. Mycotic or bacterial superinfection may occur.

Adverse Reactions: Irritation or pain at the injection site, skin rash, drug fever, headache and paresthesias.

Dosage and Administration: The maximum total daily dose should not exceed 1.5 Gm. by all routes of administration. The usual dose is 7.5 mg./Kg./12 hours I.M. The average adult dose is 1 Gm. daily. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours. If no response occurs in 3 to 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours. The drug should not be physically mixed with other antimicrobials.

Supplied: Rubber capped vials as a ready-to-use sterile aqueous solution in two concentrations: 0.5 Gm. in 2 ml. and 1.0 Gm. in 3 ml. Also available—Pediatric Injection 75 mg. in 2 ml. A.H.F.S. Category 8:12.28

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Letters to the editor

To the Editor:

Dr. Lloyd Hill's remarks are aptly titled. Most talk in the lounge is opinionated, narrow, full of hyperbole. Dr. Hill's *Lounge Talk* is no exception to this generalization.

Many of us won't take him seriously. But we are all of us serious about the principles that guide (or should guide) us in conducting the higher practical affairs of medicine.

Dr. Hill made his views eminently clear in his first essay. (One wonders why he belabors the point month after month). He is unalterably opposed to open-mindedness when considering ways to improve our health-care system. He favors the status quo. He seeks answers to questions (issuing from new experience) from the dogmas and doctrines of the past. Change according to Dr. Hill is acceptable only when it results from the willy-nilly circumstance of accident.

It's incredible that physicians who have wrought so much good through the technique of physical discovery and invention shall deny themselves of the scientific method and experimentation when confronted with important problems in their social affairs.

Sincerely yours,
JAMES E. KEPLINGER, M.D.
Lafayette

Letter to the President

To Dr. Lowell Steen and members of the Indiana State Medical Association:

Dear Sirs:

Because of the generosity of ISMA in providing $500 for Indiana University's SAMA chapter, we were able to send a delegate, alternate delegate and five other participants to this year's national SAMA convention in Philadelphia May 5th-9th. There were some 75 resolutions which came before the reference committees and the House of Delegates for discussion, debate and then voting. These will appear in their final form in an upcoming issue of our magazine, *The New Physician*, a copy of which will be provided for your library. Many of these resolutions dealt with topics extremely relevant to the medical community.

As recently as five or ten years ago much of what was discussed and voted upon would have been considered so controversial and radical that many physicians across the country might have shuddered in fear of the direction the profession's young members were headed. And, some few of the resolutions will undoubtedly still turn heads in disbelief. Yet, I feel what impressed me as much as anything was that such a great number of these issues which have demanded attention for so long, ignored even still by many state medical associations, are currently being wrestled with by our own ISMA.

From my own admittedly limited participation in the proceedings of ISMA last year I was privileged to witness the beginnings of debate and action on many topics with which our resolutions dealt. To mention only a few: the morass of legality and illegality now inadequately controlling the practice of abortion by physicians, the problem of an equitable and enforceable system of peer review, and the possibility of a need for some form of relicensure commensurate with acquisition of the minimal knowledge of new medical developments deemed imperative for the adequate practice of medicine.

I think this is indicative of the fact that SAMA is interested in solving the same problems and inadequacies as organized medicine in this state. As you know, the ISMA was among the leaders in the now fastly growing trend to grant seats in their House of Delegates to two SAMA members. This was designed to create a means of communication and feedback with the sometimes forgotten segment of the medical community—the student physician. A number of the ISMA commissions will also again have student participants on them. This type of participation in organized state medicine can serve to stimulate an interest in Indiana as a place of setting up practice in addition to the hoped for goal of creating fruitful discussion and introduction of new ideas to the commissions' attention.

I hope this coming year as president of Indiana's SAMA chapter to be of assistance in generation of new avenues of communication between our two organizations and ultimately help in some small way to make this a fruitful year for both SAMA and the ISMA.

Sincerely yours,
PETER RAY FOSTER
President, Indiana SAMA

From Mr. Waggener's Mailbox

Dear Mr. Waggener:

I am enclosing a copy of a letter I received today from the Social Security Administration concerning its report which lists five Indiana physicians as having received more than $25,000 in Medicaid payments in 1968.

I trust you will find the Administration's response to be self-explanatory.

If I can be of additional service to you, please do not hesitate to let me know.

Sincerely,
LEE H. HAMILTON, M.C.

Dear Mr. Hamilton:

I regret the delay in responding further to your inquiry on behalf of Mr. Jas. A. Waggener, Executive Secretary, Indiana State Medical Association, 3935 North Meridian Street, Indianapolis, Indiana 46208.

It is true that the Medicaid program did not become operative in Indiana until January 1, 1970. However, the Social and Rehabilitation Service of the Department (which administers the public assistance program on the Federal level) informs us that the Indiana Public Welfare Department was making medical vendor payments under Titles I, IV, X, and XIV of the Social Security Act during 1968, and these are the payments that were referred to in the Staff Report of the Committee on Finance.

It should be emphasized that the mention of the five physicians in the report does not constitute evidence of any wrongdoing on their part or on the part of the state. To the best of our knowledge, the amounts paid to these physicians were correct and proper. If Mr. Waggener still desires the names of these five physicians, we have been informed that the Indiana Welfare Department will supply him with the information.

As you know, Section 1106 of the Social Security Act and the regulation established thereunder require that all information obtained in the administration of the social security programs, including Medicare, be maintained as confidential. The regulation was amended to authorize submittal by the carrier to appropriate professional societies and state licensing agencies of information obtained in the administration of the Medicare program indicating unethical practices or unprofessional conduct by physicians or other practitioners in furnishing services to beneficiaries.

The Social Security Administration furnished the Senate Finance Committee at its request, with a list of individual physicians who have received Medicare payments in excess of $25,000.00. It should be stressed that the appearance of a physician's name on such a list is certainly no indication of any impropriety on the part of that physician. In testifying during the Senate Finance Committee hearings on administration of the Medicare and Medicaid programs, both Under Secretary Veneman and I emphasized that we have no evidence of impropriety on the part of more than a very small minority of the physicians who have rendered services covered by these programs. Since the Medicare program began we have consistently received full cooperation from the physician community, who are as anxious as we are to prevent the improper practices of a few physicians from damaging the excellent performance record of the whole profession.

Sincerely yours,

ROBERT M. BALL

Commissioner of Social Security

The following letter is in answer to a request to Dr. Kenney for information about executive health examination programs.

Dear Mr. Villanueva:

I gained the impression that there are far too many surveys being made on the medical profession. This is also the concept of our State Society, and they have so informed members of the State Association not to be answering such questionnaires, unless they are much more clearly authorized documents as to their origin and need.

The physicians in general have been over-solicited and much of the information that they have kindly presented to these surveys has, in essence, been used to their detriment rather than to their benefit. I hope that the other 230,000 physicians in America take the same attitude that I have on this.

Cordially yours,

F. D. KENNEY, M.D.

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From *The Journal* 50 Years Ago

It is surprising that obstetrics has fallen so far behind surgery in devising and perfecting methods of alleviating pain. The use of so-called twilight sleep in labor, because of some unfortunate publicity and because of indiscriminate use in the hands of unqualified physicians, has suffered an eclipse. There are evidences that the method is gaining favor among careful physicians . . . .

The literature is agreed that, except in rare cases, the initial dose of 1/6 to 1/4 gr. of morphin [sic] should not be repeated. The first dose of scopolamin [sic] or hyoscin [sic] averages about 1/150 gr. Following this the dosage varies from 1/450 to 1/150 gr. of the drug, gauged according to the degree of narcosis. The reports decry adhering to a schedule in dosage, and insist on individualizing each case.

It is the consensus of opinion that the pains should be regular and strong before any injections are given. Many prefer to be guided by vaginal examinations, in which case, the injections are begun in the primipara when the cervix shows about two fingers dilatation. It is generally agreed that delivery ought not follow the injection of morphin closer than two and one-half to three hours, else the danger of asphyxia of the child is considerable.

Practically all writers insist upon environmental precautions to exclude all external stimuli. This includes a quiet and darkened room, plugging of the ears, and the interdiction of all conversation above a whisper in the delivery room. The patient should be placed on the delivery bed before the induction of narcosis is begun. It is suggested by some that the patient ought to be allowed to sleep undisturbed following her delivery, and should not be questioned about her labor until several hours later . . . . A. R. Barnes, M.D., "Twilight Sleep," *JISMA*, August, 1920.

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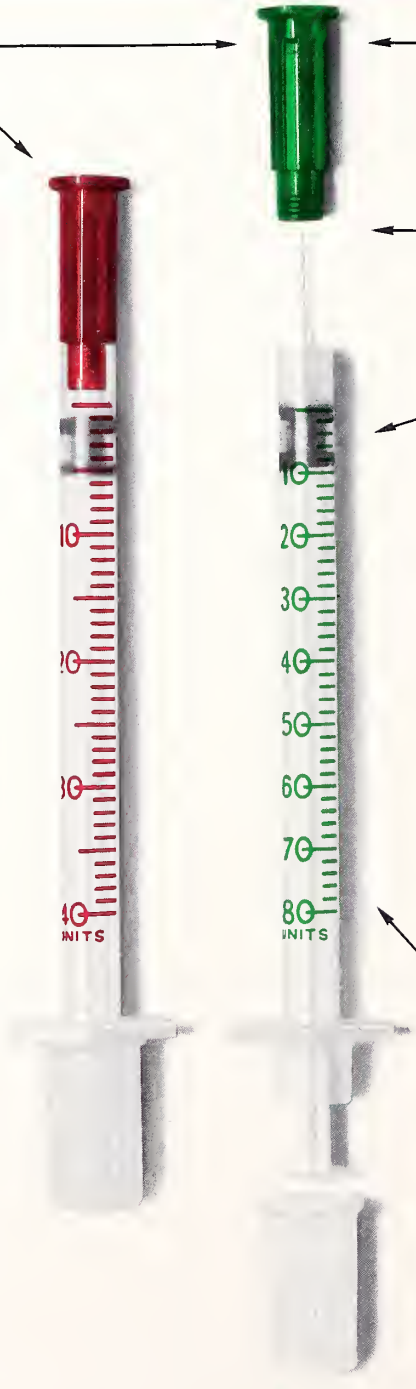
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single-scale PLASTIPAK insulin syringe needle units eliminate the hazard of reading the wrong scale

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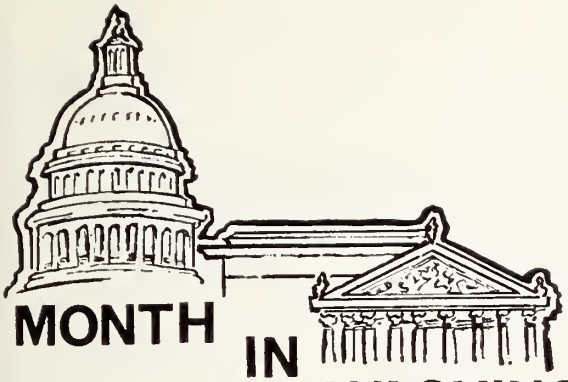
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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

AN American Medical Association proposal for peer review for the medicare and medicaid programs drew favorable reaction from members of the Senate Finance Committee.

PEER REVIEW was one part of a three-point program which Dr. Gerald D. Dorman, the outgoing president of the AMA, offered in testimony at a Senate Finance Committee hearing on medicare and medicaid.

DR. DORMAN and Dr. Julius W. Hill, president of the National Medical Association, testified together. They jointly urged on behalf of their organizations that Congress replace medicaid with a national health insurance program subsidized by the federal government.

THE AMA health insurance proposal, which initially was approved by the AMA House of Delegates in 1968, was similar to the plan President Nixon included recently in his proposed revised new national welfare program. He said he would send such legislation to Congress early next year.

CONGRESS is not expected to take up this year proposals for national health insurance. But reaction to the peer review proposal was highly encouraging, and prospects for Congressional approval this year appeared good. Sen. Wallace F. Bennett (R., Utah), a finance committee member, directed the committee's staff to work with AMA staff representatives in drafting such legislation as an amendment to a bill revising medicare and medicaid.

THE PRESIDENTS of the AMA, with 223,000 members, and the predominantly negro NMA gave assurance at the finance committee hearing of the medical professsion's cooperation in solving the nation's health care problems. It was the first time that spokesmen for the two leading medical associations had testified together before a Congressional committee.

DR. DORMAN SAID "the medical profession hopes to see the nation pursue" the three-point program in efforts to provide quality health care for everyone as economically as possible.

DR. HILL SAID the insurance plan would work better than medicaid in the ghettoes. He also defended physicians against accusations that they have been profiteering under medicaid and medicare.

THE FIRST TWO PARTS of the AMA program comprised the association's "medicredit" health insurance plan. The third, peer review, "is a way to assure both scientific quality and economic reasonableness

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in the medical and health care people get," Dr. Dorman said.

"OUR FIRST PROGRAM would meet the problems of the Title XIX medicaid program," Dr. Dorman said. "Under our plan, each low income person or family would receive a certificate for the purchase of a qualified and comprehensive health insurance plan. The protection would be theirs without expense or contribution since the cost of the program would be borne entirely by the federal government.

"THE SECOND offers tax credits, on a sliding scale based on the tax liability of a family, for the purchase of qualified health benefits coverage. For those with moderate or higher levels of income, the program would provide cash incentives, through income tax credits, to encourage them to protect themselves against major health care costs.

"THE THIRD PART of our program calls for a structured peer review mechanism to insure high quality of care and to prevent abuses of the medicare and medicaid programs."

DR. DORMAN noted that the committee's staff in a report last February on medicare-medicaid suggested that organized medicine regulate itself.

"WE AGREE, and propose a program providing for professional review of matters bearing on reasonableness of charges for, need for, and the quality of services rendered by, the provider of medical or other health services," he said.

IN A SPEECH on the Senate floor, Bennett said there is deep concern over the high costs of medicare and medicaid. He complimented the AMA on advancing peer review as a means of curbing these costs. He said:

"I BELIEVE the American people are justifiably concerned over the tremendous costs of health care. Much of that concern, it seems to me, is a product of a very real feeling that we are not getting what we are paying for. I believe, equally, that much of the apprehension, anxiety, and suspicion now prevalent—for better or worse—with respect to those responsible for health care would disappear if professional standards review organizations were established and functioned effectively. It seems to me that the American people are entitled to know that American medicine shares their concern—and more importantly—proposes to do something substantial about it through means of professional standards review organizations . . . .

"I BELIEVE that physicians, properly organized and with a proper mandate, are capable of conducting an ongoing effective review program which would eliminate much of the present criticism of the profession and help enhance their stature as honorable men in an honorable vocation willing to undertake necessary and broad responsibility for overseeing professional functions. If medicine accepts this role and fulfills its responsibility, then the Government would not need to devote its energies and resources to this area of concern. Make no

mistake: the direction of the House-passed social security bill is toward more—not less—review of the need for and quality of health care. I believe my amendment would provide the necessary means by which organized medicine could assume responsibility for that review."

BENNETT SAID THAT, under his amendment, review groups would have responsibility for reviewing "the totality of care provided patients—including all institutional care." That responsibility, he said, would be lodged, "wherever possible and wherever feasible," at the local community level. He said:

"LOCAL EMPHASIS is necessary because the practice of medicine may vary, within reasonable limits, from area to area, and local review assures greater familiarity with the physicians involved and ready access to necessary data. Priority should be given to arrangements with local medical societies—of suitable size—which are willing and capable of undertaking comprehensive professional standards review . . . .

"UNDER THE AMENDMENT, the Secretary [of Health, Education and Welfare] could use state or local health departments or employ other suitable means of undertaking professional standards review only where the medical societies were unwilling or unable to do the necessary work, or where their efforts were only pro forma or token. Let me emphasize as strongly as possible that the thrust of this proposal is to have physicians, as a group, evaluate physicians and the services they provide and order as individuals."

BENNETT SAID THAT the review committees should determine that only medically necessary services are provided by physicians, hospitals, nursing homes and pharmacies, and that these services meet proper professional standards.

DISCIPLINARY MEASURES, he said, would be in proportion to the offense and could include: 1) monetary penalties, 2) suspension from federal programs, 3) exclusion from federal programs, 4) civil or criminal prosecution, and 5) steps leading to the suspension or revocation of professional licensure.

DR. HILL directed his testimony before the finance committee mainly to medical care of the blacks and other poor people, particularly in ghettoes. He took issue with the committee staff report which, he said, "by implication attacked the very physicians working closest to the poor and treating them." He said restrictions upon physicians' fees, as advocated in the report, would make more acute the already critical shortage of physicians in ghettoes.

"TO THOSE WHO read the entire report, there were a number of very complimentary things said about all physicians," Dr. Hill said. "But the primary message, the one seized upon by the press and broadcast across the country, appeared to be that any doctor earning a substantial amount of money from medicare-medicaid was somehow cheating both the government and his patients.

"IT WAS BITTERLY IRONIC. To work 60 and more hours a week in the ghetto, and to be

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fairly paid, was suddenly prima facie evidence of wrong-doing.

"THE REPORT was also interpreted so that the blame for the rising cost of medicare-medicaid was directed at the physician—and particularly those caring for the poor.

"THEREFORE, we of the National Medical Association take strong exception. The implications and accusations of that report were grossly unfair. It is difficult enough to get physicians to practice among the poor . . . . If these men, professionals committed to providing care, are to be subjected to irresponsible accusations for the size and success of their ghetto practices, it will very soon be impossible to find a doctor among the American poor."

THE ASSOCIATIONS showed the senators a brief movie of physicians practicing in a Chicago ghetto health canter and in an Appalachian community clinic.

NO POLIO DEATHS REPORTED IN 1969

THE National Communicable Disease Center of the U. S. Public Health Service said that not a single death from polio was reported in the nation last year.

IT WAS THE FIRST time no death from the disease was reported since 1955 when regular polio surveillance was started. In addition to the absence of a death, the total number of cases of paralytic polio was only 19.

BEFORE THE introduction of polio vaccine during the mid 1950's, annual paralytic cases went as high as 21,300 with 1,400 deaths. The number of cases began to dwindle after use of the vaccine became widespread and 1960, with 230 cases, was the last year when the number of deaths exceeded 100. In recent years, the death toll usually has been between 10 and 20.

AMONG THE 19 paralytic cases last year, only one occurred in a person who had received a full series of anti-polio doses. The exception was a two-year-old suffering from an inborn inability to form protective antibodies against bacteria and viruses.

AN ESTIMATED 26.5 million doses of vaccine, most of it the oral type, was administered nationwide last year.

A FEDERAL health official warned that small outbreaks of polio still are possible in city slums and other areas where it is difficult to achieve 100% immunization. There already have been 11 known cases and one death in the Rio Grande Valley citrus-growing region of Texas where there was a problem of convincing parents of the need for immunizing. ◄

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION
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Should We Try to Find More Diseases When We Can't Cure the Ones We've Got?*

MICHAEL J. HALBERSTAM, M.D.
Washington, D.C.**

NOW, like most doctors today I take a fair amount of time off from my practice, more than my physician father or uncle ever did. However, even with a week of medical meetings and three or four weeks of vacation, I am available to my patients nine out of ten nights, nine out of ten weekends. This is not the burden it seems, because my patients are rational about calling me at home. When the phone does ring at night, I don't have to deal with a patient I have never seen before. The patient is not confronted by a vaguely resentful doctor. I talk to someone whom I have examined before, whose history I know. I have an idea of how this particular person reacts to pain, whether he's stoic or panicky. Something they never teach in medical school is that the really tough decisions of today's medicine—hospital? house call? aspirin until morning?—are made over the phone, and then that pushcart industry doesn't look like such a bad idea after all. Real economies are achieved by reliable medical transactions over the phone day and night.

I am not saying that group practice and prepaid groups are bad medically or philosophically. I am pointing out that these arrangements have their inherent disadvantages as well as advantages, and that these disadvantages have been glossed over by many proponents. There is no doubt that fee-for-service tempts the greedy physician to provide unneeded services. On the other hand, salaried practice tempts the lazy physician to prolonged coffee breaks and extra reasons for not operating on a weekend. Institutions *can* provide ancillary services that the individual doctor cannot. However, it is axiomatic that the physician working for an institution, paid by the institution, must at times divide his loyalty between the patient and the institution.

Bigness, it should be added, is no guarantee of inefficiency. The Federal Government is hardly rational in its own allocation of physician-manpower (one could service several states with the doctors tucked away in various programs) and our great hospitals sometimes act like suburban housewives trying to impress one another with expensive acquisitions.

So I continue to practice by myself. I am not "isolated," as my critics would have it, for like almost all other physicians I must adhere to the standards of my local medical society, my colleagues, my specialty group, and the hospitals which have granted me admitting privileges. Working in a great city, I have access to dozens of other specialists, social workers and therapists. Some of us practice in the same medical building, but our finances are not intertwined. I treat all kinds of patients and I enjoy my work. I don't mind piecework payment—most professionals are paid this way and so is Renata Tebaldi. My practice is flexible and I don't have to worry about what my supervisor will say or whether O.E.O. is going to be funded this year. I don't have to worry about hurting my partner's feelings when I leave the cap off the lubricating jelly, because I don't have a partner. When I do indulge in political activism, I don't have to brood about damaging my employer's repu-

* Originally published under the title of "The M. D. Should Not Try to Cure Society," the *New York Times Magazine*, Nov. 9, 1969.

** Michael Halberstam, M.D., spent a year or more in medical training or practice in Boston, the Bronx, Point Barrow (Alaska), Crownpoint (N. M.) and Burlington (Vt.). For the last five years he has been in the private practice of internal medicine in Washington.

tation or invoking his subtle retaliation.

My friend, Nelson Goodman, practices in a prepaid group and he can't understand why I won't join up. He loves the lack of concern about billing patients, the freedom from business details. America's "nonsystem" of care provides multiple options within medicine for both doctors and patients. Nelson works best in his group, I work best in my un-group. His patients prefer a group, mine prefer a private practitioner (some of my patients used to belong to his group—and vice versa, I suppose).

The argument that private practice is a luxury which exists merely for the benefit of physicians not only ignores the points previously made, but skips the harsh fact that physician contentment is basic to any kind of practice scheme. Emigration of British physicians continues to bedevil the country's National Health Plan, discontent arising not only from heavy patient loads and bureaucratic restrictions, but also from a rigidly structured system of hospital specialists. A study of recent graduates of Aberdeen University showed that more than a quarter had emigrated. Doctors, like other humans, can vote with their feet.

Some economists, like Milton Roemer of U.C.L.A., feel that group practice is particularly desirable because it will enable consumer groups to bargain effectively with the providers of medical services. In this way fees, insurance and premiums could be held down. The trouble with this theory is that it assumes the providers of services won't organize as well. Despite the idea that doctors' fees are set by some kind of guild fiat, they are instead a matter of local custom. When fees go up, they do so almost by osmosis—one doctor raises his charges, tells his friends, they look at their books and decide to follow suit. If consumers and insurance companies start to bargain forcefully about fees, there is no doubt that physicians will do the same. Relative costs will not change very much.

Physicians will continue to be rather affluent people. Of all the complaints about doctors, this is the one which moves me the least. Concern about other people's income, whether they are pop singers, football players, neighbors, or fellow professionals, has always seemed a pawky way to dissipate one's energies. It bothers me most when one physician talks about another specialty—for example, an internist complaining about surgeons: "We get up in the middle of the night, spend an hour with the patient at home, make the diagnosis, call in the surgeon, and he operates for 45 minutes. We get $25 and he gets $250. Is that fair?"

My answer is basically, "Yes." I knew in medical school that internists earned less than surgeons, but no amount of money in the world would have made me want to be a surgeon. So far as I'm concerned, surgeons earn what they get. If internists don't earn enough, they ought to organize to change this without worrying about other specialists. Just for the record, I would add that I would have no objection to getting rich through practicing internal medicine, but to the best of my knowledge it can't be done. My colleagues and I live solidly comfortable lives, just like most of our friends who went on from graduate school to business, *academia* or other professions.

Rather than brood about physicians' income, reformers should, as economist Fuchs has suggested, work to make medical insurance universal. The A.M.A. itself has accepted the principle of such insurance, but wants it provided through private carriers. Fuchs is for group-insurance plans that would include both the nonpoor and the poor, the latter to have their premiums subsidized by the Government. "Luxury options" would be allowed for those who value medical care above competing services, but basic care would be provided for all. I feel fairly sure that in 10 years a plan like Fuchs' or the A.M.A.'s will be in force.

In the next decade there will be significant evolutionary changes in American medicine, which will, I hope, become more humane and more patient-centered. Research will lose more of its primacy. Practicing physicians will start to pay more attention to the deeper needs of the poor—medical schools and teaching hospitals will start to pay some. A variety of occupations will grow up to supplant doctors in some procedures and assist them in others. Group practice, including prepaid, will continue to grow slowly but steadily. The hospitals will have an increasingly important role in regulating how doctors practice. All Americans will be covered by some kind of medical insurance, either by private companies or, if they are poor or old, through Government reinsurance. Instead of today's compulsory military service, which makes medicine unique among the professions, future doctors may have the option of serving in poverty programs.

These reforms will relieve some of the more hurtful inequities of today's medicine, but I doubt if the medical profession will be any safer from criticism than it is today. For built into all of us is a profound ambivalence about the healer. We respect the physician and when we are ill we are genuinely grateful for his knowledge and compassion. Yet, when we have recovered, a bit of resentment often creeps in. For, despite what the World Health Organization feels, "health" for most of us is not a positive sensation, but an absence of negative ones. We do not routinely wake up and say, "How good to breathe easily, step lightly, and feel no pain in my head or chest."

We take these things for granted, and if we get sick, the physician who restores us to normal—or who helps while nature is restoring—has, in the long run, given us only what we had always taken for granted, and, usually, will soon start taking for granted again. Thus, when illness is over we resent the very dependence on the physician which sustained us while sick. He now becomes a reminder of our weakness and of the nasty fact that we are not eternal.

Neither the mature patient nor the mature physician expects their relationship to be one of unquestioned love and admiration. The link between doctor and patient, like that between parent and child, is too important to be tranquil. Conflict and resentment are inevitable, but these do not preclude mutual respect. The physician will continue to be the one we call when a bad pain awakens us at night. There is no one else who both cares and can do something about it. ◄

Medical annals of the poor

What our mortality figures reflect most horrifyingly is a problem that we barely knew existed 30 years ago. When most Negroes lived in the South—the rural South—infants were born and died literally without number, without ever having made a statistical imprint. Talk to women in their 50's who were born in rural Virginia and North Carolina. "I have six kids grown, two more died when they was born." They were born at home, their births never registered. Why register a dead baby?

The accelerating migration of blacks to cities in the South and then to the North itself brought them all the blessing of modern statistics. For if the city health departments could not motivate frightened girls to come to their prenatal clinics, if they could not provide cheerful maternity rooms and sympathetic care, they could at least count dead babies.

That our health statistics are skewed badly by disproportionate rates of disease in the nonwhite population (Indian, Mexican-American, as well as black) does not excuse American medicine from responsibility. It does, however, make improving the health of that population an infinitely more complex job than just dropping a few more doctors into neighborhood health centers. Sociologists have shown that the death rate of young Negro men in the cities is four times that of whites the same age, but the deaths are from social pathology—homicides, accidents, drugs—rather than "medical" conditions.

When former Surgeon General William Stewart referred to the link between illness and poverty in the phrase, "The poor get sick, and the sick get poorer," he was citing only one of the facets and one of the less important ones, at that—in a complex interrelationship. Numerous studies from England and this country have shown that the degree of physical impairment is less important than other factors in determining whether a "sick" man can work or return to work. Among these other factors are how much he enjoys his work, how important it is, what his ethnic background is, what his childhood was like. Dr. Arthur McMahon of Tufts has shown that for many middle-aged workers an accident becomes an acceptable excuse to give up on a life or a job that never provided much pleasure. Dr. Harold Silver of Washington found no significant difference in pulmonary function between a group of private patients working regularly and a group of welfare patients who considered themselves disabled by lung disease. The overriding importance of how one feels about one's work as a determinant of disability can be seen by looking at the Senate or the White House, where there are and have been many vigorous politicians theoretically eligible for complete physical disability.

This does not argue against providing medical services for the poor. Medical services should be provided for the poor, but they should be provided because the sick should have care. The expectation that the cycle of poverty will often be reversed is unwarranted. In many cases "sick" people could be returned to a productive life, not by giving them better medical care, but by offering them better jobs. Spending more on medical care in such cases would be a diversion of funds from where they would do the most good.—M. H.

A Family Practice Residency In a Community Hospital

ROSS L. EGGER, M.D.
Daleville*

PROBABLY the most significant event occurring during the long struggle to establish a specialty of Family Practice was the publication and distribution of several independent non-collaborative reports in 1966. These reports reflected the feelings of: the government;[1] the lay public[2] and organized medicine.[3] These reports concluded that: 1) the public wants a personal physician; 2) his function should be comprehensive and continuing in scope; 3) he should be on a par with all other specialists and 4) a primary specialty board should be developed with appropriate training programs to produce candidates.

The next important event was the development of "Essentials for a Family Practice Residency"[4] in December, 1968. The Joint Commission of Accreditation had approved several "experimental" family practice programs several years prior to the development of the "Essentials" and the experience gained from these programs was used to some extent in framing the "Essentials." Since the development of the "Essentials for a Family Practice Residency," several of the experimental programs and several new programs have been approved by the newly formed Family Practice Residency Review Committee. As of January 1, 1970, there are 31 approved residencies in family practice in the United States, two of which are in Indiana, collectively providing positions for over 100 first-year residents.

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But isn't a family practice residency simply a modern version of a general practice residency? That is a frequent question posed to me. The answer is obviously no. One simply has to compare the essentials for a general practice residency with the essentials for a family practice residency.

The main features that differentiate a family practice residency from a general practice residency are: in the former, the resident practices on ambulatory patients not necessarily ill, and the core content of what is to be taught is well defined.

The community hospital is an ideal institution in which to establish a family practice residency. The three main features necessary to provide a community hospital family practice residency program are: 1) families; 2) a model office in which to practice and 3) a medical staff adequately trained and motivated.

Needs Families

The program must have families. The resident must assume the total care of families for the duration of the program. This would include such things as prenatal care, obstetrics, newborn care, infant care, routine and insurance examinations, immunizations, routine office care and hospitalizations. He must assume responsibility for the total health needs of his families. Families should be brought into the program during the resident's first year. This can be best accomplished through the prenatal clinic experience and emergency room rotation. The resident can be instructed to invite any patient who does not have a family doctor to his service. Each resident should have a "core" of families totaling 50 to 100 by his second year.

A model family practice office is necessary. The residents must have an "office" in which to practice. This office should contain a waiting room, consultation rooms, business office, examination rooms and appropriate nurses, receptionists and technicians. A laboratory is desirable, as is an x-ray if practical. The patient's records should be kept in this office and all billing and collections should be made from there. Each resident should have his "turn" at managing this office including ordering supplies and reviewing collections. Patients should be charged the same fees as are customary for the area. In short, the office should be identical to an ideal family physician's office.

At least 50% of the resident's time should be spent in the family practice model during the three-year training period. Outpatient clinics are far from this ideal, especially when a common waiting room and staff must be shared with other specialties. A more ideal model would be a building or vacated doctor's office adjacent to the hospital. An alternative method of developing a core of families would be to have a family physician or a small group of family physicians move their practice into the family practice model and be appointed as the family practice teaching staff.

A medical staff adequately trained and motivated is essential. All of the specialties should participate in the training of the family practice residents. The first year may be spent on rotation, much as a rotating internship, exposing the resident to the knowledge and skills of the other specialties. Appropriate conferences must be developed to assure adequate exposure to the core of knowledge necessary for family practice. A large portion of this knowledge

to be mastered is in the behavioral sciences.[5] A nearby liberal arts college or a guest lectureship are excellent means of teaching the behavioral science portion of the residency. Supervision in the family practice model should be by practicing family physicians and is one of the most vital learning experiences in patient management to which residents are exposed.

When properly planned and directed, a family practice residency in a community hospital is an ideal training program for family practice. There are also several advantages to the participating hospital staff: 1) the quality of medicine practiced in the community is improved by aggressive, questioning young minds; 2) adequate exposure to the needs of the community and to the medical community increases the probability of these residents remaining in the area following training; 3) the model offers an ideal area for research in patient care; 4) it complements and allows practical experience for other medical personnel training programs such as registered nurses and practical nurses; 5) the critical health manpower shortage is slightly lessened in the community and 6) it can involve many more doctors as teachers than most other residencies. Last but not least, these programs can pay for themselves.

Accepting the Challenge

In summary, the family physician is now a reality with the first board examination completed. We now have the task of developing sufficient numbers of residency programs to produce a significant impact on the health care system. A family practice residency is a program based on developing skills in many areas of medicine and in the behavioral sciences and finally, and most importantly, practicing these skills on ambulatory families during illness and health in a model family practice office.

Family practice is an attitude that can only be taught by practicing on families, not illnesses. The community hospital offers not only an adequate setting for these programs but, in most instances, the ideal setting. It has two obvious advantages—families, and a community, and is not so steeped in intradepartmental traditions and allegiances that intradisciplinary programs such as family practice cannot succeed.

The family practice movement has proven itself and is here to stay. Ours is the task of accepting the challenge and producing this new breed of physicians. The returns to a community and its hospital so far outweigh the time and devotion put into this program and its acceptance by the hospital, board and the community is almost universal.

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THIS is the age of the alphabet. Everywhere we turn, we hear IRS, DOT, FAA, DOA, EKG, FCC, EMS and many more. Although all are important, the last of these may well affect your everyday lives more than any of the others over the next few years. EMS is Emergency Medical Services.

What are Emergency Medical Services? According to the U. S. Department of Transportation, EMS "connotes the complete system of emergency care provided for in Highway Safety Program Standard No. 4.4.11, including first aid given by bystanders, emergency care rendered by specially-trained ambulance attendants or other personnel, and medical care rendered by physicians or qualified personnel under their direct supervision."[1]

How far has this program progressed in our state? The Governor has appointed the Indiana State Board of Health as the agency to direct planning and implementation of the Emergency Medical Services program as required under the Highway Safety Act of 1966. After almost two years of hard work by people from all over the state representing medical and allied fields, the master plan is finished.[2] The next step will be legislation in such areas as ambulance ordinances, certification and training of emergency personnel, certification of emergency treatment centers, possible funding of ambulance services and communication networks, and a comprehensive record collecting and retrieval system.

How does this master plan relate to your individual community? It is quite likely some of your neighbors have been involved in this comprehensive planning on a statewide level. This is of undeniable importance but is not half as important to you as organizing your own community to local action.

* Director, Ambulance Division, Marion County General Hospital, Indianapolis 46202.

Background

Early in 1967, the American Medical Association jumped into this problem with both feet. A Committee on Emergency Medical Services was formed and the first meetings were held.[3] The basic recommendation emerging from these meetings was that the medical profession in a community accept the responsibility for spearheading the creation of a local Emergency Medical Service Council. This council was envisioned as a community-wide program eliminating previous problems such as lack of co-ordination, fragmentation of effort and apathy on the part of government officials and public. It had to agree on goals, and, sooner or later, had to spend some of the community's money. It had to provide its citizens with adequate first aid care, prompt ambulance service, good emergency communications, and sufficient hospital and emergency medical facilities.

Who should be on such a committee? Representatives of police and fire organizations, of local hospital administration, of private ambulance services, of the medical society, and of the local health department are obvious selections. Not so obvious is the fact that the consumer should be represented. He might logically voice his opinions through representatives from the Chamber of Commerce, service clubs, labor unions and Parent Teacher Associations. The Emergency Medical Services Committee should strive to be county-wide; or perhaps in the light of the Indiana plan, region-wide. It must make use of talents of people already involved in the emergency medical services field and must search out those who are potential assets.

Evaluate, Establish Goals

What next? Using the basic framework as recommended by those initial AMA committees some years ago, the following outline could be prepared:

I. *Evaluate the present situation.* You will note that the four basic areas of EMS are rescue and first aid, transportation, communication, and emergency medical facilities. Publications are coming out faster than one can read them with recommendations for effective organization at each of these levels. Specific check lists have been available for some time covering ambulance services and emergency medical hospital facilities. With aids such as these available, the first and most logical step for any community is to see what they have on hand.

II. *Establish goals.* In my experience, this is where you separate the men from the mice. If you went door to door in any community and asked each individual citizen what kind of emergency medical service they wanted, they would answer in one mighty chorus "the best there is." If you go around again and tell them what it will cost, the chorus

will sing another tune. You will probably have to settle for flying tourist class rather than first class, but this is still better than not getting off the ground at all. So, find out what you can and want to afford and judge your goals accordingly.

III. *Form a plan of action.* Here again, we divide our efforts into the four basic fields of emergency medical services.

A. Rescue and first aid:

1. Beginning with organized public safety organizations such as police and fire departments, upgrade their first aid training to that of advanced Red Cross standards.
2. With the assistance of members of the county medical society to provide medical teaching, train local ambulance personnel to a level even higher than advanced Red Cross. The National Standard Program for emergency medical technicians will be 72 hours.
3. Broaden the base of first aid availability by assisting organizations such as the Red Cross in expanding courses for school children, adults, factory workers, truck drivers, etc.



FIGURE 1
DR. Jerry R. Miller, Indianapolis anesthesiologist, instructs rescue squad personnel in proper use of bag and mask.

B. Transportation: In this field, one of the first decisions to be made as to a goal should be the acceptable response time of an ambulance in your community. If your citizens will agree to wait ten minutes for an ambulance, this part of your program is going to cost a lot less than if they become exceedingly impatient after waiting six minutes. The recent Dunlop Report explores mathematically the methods for arriving at the number and distribution of ambulances needed to provide a specific response time.[4] Geographic considerations are important; ambulances have to stick to the roads and don't necessarily travel a straight line between two points. The vehicle itself should conform to the tentative recommendations presently available from the Department of Transportation.[5] An acceptable, standardized, mass-produced ambulance will probably be available within the next two or three years. Until that time, current ambulance vehicles, except the station wagon type, are acceptable. The ambulance must carry two E.M.T.s, adequately trained. It must have radio communication with a central dispatching agency. It must carry items specified in the newly updated essential equipment list provided by the American College of Surgeons. It should be noted that this list now includes rescue-extrication tools to be carried where separate rescue services are not available. If community transportation is provided by a private ambulance company or by a funeral director, the rather thorny issues of exclusive contracts and public subsidy must be discussed. Legislative efforts are now being mounted toward passage of a modification of the Good Samaritan Law so that it covers personnel such as emergency medical technicians in addition to physicians. Legislation in the form of a statewide ambulance ordinance will also help in the upgrading of local services.

C. Communications: Except in basically rural areas, most communities have some central emergency communication facility. Obviously, local planning will vary greatly from place to place. The Indiana plan envisions a local police agency as the usual dispatch medium but this may be a fire department or an ambulance service if such is more suitable. In larger cities,



FIGURE 2

INDIANAPOLIS Fire Rescue Squad members demonstrate proper emergency technics using a mock highway accident victim.

an EMS control center for dispatch of all rescue and ambulance equipment, both private and municipal, will be desirable. The basic necessities in communication are:

1. A 24-hour dispatch center available by one phone number in a given region. Incidentally, these facilities should be manned by dispatchers who are as well trained, if not better, than the ambulance crews themselves.
2. Voice communication must be provided between the ambulance and the hospital emergency facility.
3. Voice communication must be available between this central dispatcher and local police and fire organizations.
4. Adequate record keeping must be developed and maintained.

The Indiana Hospital Association last year approved a hospital administrative radio network involving the 13 emergency service regions in the state. This two frequency radio network would be based at the hospitals with the licenses retained by the hospital. The local frequency would link all hospitals in that region and serve the operations of local ambulance services and key medical and hospital personnel. The regional frequency would allow communication between other state EMS regions. Approximately 12 hospitals in this state are at this time operating such communication facilities and more are in the planning stage.

One of the greatest problems thus far encountered is the method by which emergency forces can be alerted to the need for their services. Emergency call boxes along interstate highways have been used successfully, but the cost is fantastic. Self-powered units do away with the need for wires, but these cost in the vicinity of $1,000 each at the present time. Depending upon situations existing in your community, the telephone company may be a strong ally by assisting in the identification of roadside telephones for emergency purposes. A nationwide road sign program to identify emergency medical facilities to the highway traveler had its beginning in the Allen County Medical Society and hopefully will be soon available throughout the country.

D. **Emergency Medical Facilities:** Under the Indiana plan, all of the hospitals in the state were evaluated according to their ability to care for emergency accident cases. These were divided into types one through four, with the first being a major trauma center with complete equipment available and the fourth being simply a first aid station or emergency clinic. In the community plan the council should focus on the ability of their hospital to render emergency care. The physicians and hospital administration should decide what they can and cannot handle. A problem which not uncommonly arises in a small community hospital is the severely injured patient who is brought in, kept for a period of time and then later sent to a larger treatment center. Better co-ordination and realization of local capabilities might decrease the time lag in such a case. The county medical society should take a searching look at the medical staffing of their emergency facility. Twenty-four hour physician availability is ob-

viously desirable. Physical layout of the emergency facility could perhaps be improved if community support was enlisted. Public education would help to check rapidly increasing jam-up of hospital emergency rooms by non-emergency patients, better than 50% of the total load in most hospitals surveyed.



FIGURE 3
NEW CASTLE-Henry County First Aid Unit; example of a well-equipped emergency ambulance.

This then is the skeleton of what EMS is as applied at the community level. This is obviously the best place to apply it. No one knows the problems, the geography, the financial resources and the temperament of people in a community better than the people themselves. The statewide program has already absorbed hours of effort on the part of many people. Unless this large scale plan can be channeled through and applied by active and dedicated community EMS councils, the end product will be less than needed to check the neglected disease of modern society, accidental death and disability.

REFERENCES

1. *Emergency Medical Service*, U.S. Department of Transportation, Highway Safety Program, Manual Volume 11, January, 1969.
2. *Indiana Emergency Medical Services Plan*, Indiana State Board of Health, Indianapolis, Indiana, 1969.
3. *Proceedings, AMA Conference on Emergency Medical Services*, American Medical Association, Dept. of Hospitals and Medical Facilities, Chicago, Ill., 1967.
4. *Economics of Highway Emergency Ambulance Services*, National Highway Safety Bureau, Dunlap and Associates, Inc., Darien, Conn.
5. *Ambulance Design Criteria*, National Academy of Engineering, Committee on Ambulance Design Criteria, Washington, D.C., 1969. ◄

Application for Space in Art and Hobby Show Exhibit

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What do you do for patients who come to you with sexual problems?

Treating the Patient with a Sexual Problem*

EDWARD A. TYLER, M.D.
*Indianapolis***

MOST receptive physicians are presented with sexual problems by their patients. These doctors usually try to help, but many feel poorly qualified to manage this kind of malady. The usual patient-care procedure (1) examining the patient, (2) making a diagnosis, and (3) prescribing therapy, is still appropriate, but many physicians do not have sufficient knowledge about human sexual problems to apply this model. Let us determine why and then offer you a prescription for modifying this condition in yourself.

All of us take our best and most pertinent histories about the illnesses with which we have the greatest sophistication. Our favorite (special) diseases are the ones about which we have learned the typical symptom picture and have sufficient background knowledge to make a cause and effect sequence out of our patient's story.

We then look, touch, and listen to the appropriate areas of our patient's body in order to confirm or reject our initial hypothesis. Finally, we select a few samples of our patient's body and send these to a laboratory for a measurement against some standardized measuring scale.

It is rare that we intentionally use moral judgment as a criterion for evaluating our patient's structural or physiological problems. However, we are very prone to use a moral scale when we are unfamiliar with the factual data—i.e., in human sexual matters.

When confronted by a "frigid" female, few of us know which questions to ask to obtain the data that will give us a logical cause and effect sequence. Our physical exam doesn't add much. We suspect, and rightly so, that the usual pelvic exam would not distinguish between the "frigid," the "normal" and the "oversexed" female. An assay of the sex hormones rarely adds anything to our understanding of our patient's sexual inadequacies.

The above would be equally true if we were trying to evaluate a homosexual or male impotence problem.

Until very recently the only things a physician was taught about human sexuality in medical school were likely to be the anatomical structure of the sex organs, the biochemical-physiological phenomena related to sex hormones and the menstrual cycle, and the technic of delivering a baby.

On the other hand, our patients present with problems of sexual *behavior*. Specifically, our patient complains that his behavioral pattern does not provide him and/or his partner with a subjectively satisfying performance.

Are Expectations Realistic?

The first question the physician must weigh is whether the patient's sexual expectations of himself and/or his partner are realistic. This isn't easy if the physician has no measuring instruments other than his own hunches and personal experiences. He commonly errs in assuming his own personal patterns, attitudes, preferences and biases are arbitrarily typical of the patient population he sees. This is about as accurate as measuring a patient's temperature by placing one's right hand on the patient's forehead and one's left hand on one's own forehead.

Unfortunately there are no short cuts to give the inexperienced physician "instant expertise." The treatment of frigidity, impotence, premature ejaculation, vaginismus, lack of sexual desire, homosexuality, etc., cannot be found in a ready reference manual. Physicians are paid to make non-programable decisions, but to do so they must understand the human biology involved.

Understanding the facts about human sexual biology is more time consuming than difficult. Developing the degree of tolerance necessary to utilize what you learn about human sexuality may prove a bit more difficult. Before embarking on any plan of study the M.D. should first be sure he personally accepts the *obligation* to treat this group of human maladies. If so, he must assume the right of *access* to the most personal data about his patient's intimate sexual life. To justify this access and effectually utilize the history he uncovers, he must have acquired some *confidence* that he knows what he is doing. Oversimplifying his confidence will be based on:

(1) a pool of accurate information about human sexual behavior,

* Presented at the annual convention of the Indiana State Medical Association, October 16, 1969, Indianapolis.

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(2) a tolerant attitude about human sexuality,
(3) a candid honesty to his patients and himself,
(4) experience with technics for modifying maladaptive human sexual behavior.

Obviously in a single journal article I cannot teach you how to treat any and all of the sexual problems which commonly present to the physician. I can't even give you a crash course in the basics of human sexuality. I have, however, outlined below a program of self-study for the physician interested in increasing his sophistication in diagnosing and treating the sexual problems which his patients present.

You should start by reading A and much of B. You may wish to skip C and D, but you should sample E. Lastly, you should periodically discuss your readings, patient experiences, and personal concepts with groups of your colleagues.

A. Read these carefully before you go on to any other item.
B. Read these as the topic interests you.
C. Browse these (read only the heavy print and summary).
D. Reference books—these should be available when you want details on a specific topic. Refer to index or contents.
E. Sources of audio-visual materials available to Indiana physicians.

All books and articles listed are in School of Medicine Library, Indiana University Medical Center, but I would suggest you purchase those listed in Section A.

A. *Human Sexual Response*, W. Masters and V. Johnson, Little, Brown & Co., 1966.
A Concept of Contraception, S. Neubardt, Trident Press, 1967.
Counseling in Marital and Sexual Problems (Chapters 1, 2, 3, 7, 10, 11, 12, 13, 14, 15), R. Klemer, Williams & Wilkins Company, 1965.

B. All of the articles listed here are from the journal *Medical Aspects of Human Sexuality*, published by Clinical Communications, 250 E. 39th Street, New York. The articles are grouped according to their relatedness. The titles are usually quite descriptive of the content.

Title	*Author*	*Vol.*	#	*Page*
Exploring Sexual Complaints	C. Langsing	I	4	34
Changing Concepts of Premarital Examination	C. Flowers	I	4	51
Examining the Young Girl and the Virgin Woman	J. Merrill	II	7	37
Physical Examination for Marriage Problems	W. Coburn	III	6	52
The Physician as Counselor in Post-Marital and Extra-Marital Pregnancies	C. Vincent	I	3	34
Modes of Treatment for Sexual Inadequacies	A. Lazarus	III	5	53
Painful Coitus	R. Kinch	I	2	6
Frigidity	Roundtable	II	2	26
Frigidity	P. Brady	I	3	42
Premature Ejaculation as a Form of Sexual Impotence	L. Wershub	I	4	43
What Do You Tell Patients Who Ask About Coital Positions?	Viewpoints	II	12	43
When Patients Ask About Various Sex Practices	Roundtable	III	2	54
The Fallacy of Equality in Sexual Relations	J. Schimel	III	8	15
Factors in Marital Orgasm	P. Gebhard	II	7	22
How Important Is Simultaneous Orgasm	Viewpoints	III	7	86
What Is the Norm for Sex Relations in Marriage	D. Reed	I	3	6
Iatrogenic Sexual Disturbances	J. Mathis	I	1	49
First Coitus	T. Lowry	III	5	91
Dating and Mating Among Teenagers	C. Broderick	II	8	16
Sexual Problems of College Students	S. Halleck	II	5	12
How Does Premarital Sex Affect Marriage?	Roundtable	II	11	14
Sexual Interest in Someone Older or Younger	C. Vincent	II	11	6
Sex During the Menstrual Period	C. Martin & E. Long	III	7	37
Geriatric Sex Behavior	E. Pfeiffer	III	6	19

Title	Author	Vol.	#	Page
The Artificial Vagina	M. Newton	II	12	28
Sex After Hysterectomy	M. Drellich	I	3	62
The Menopausal Woman and Sex Hormones	H. Kupperman	I	1	64
What Do You Tell Post-Coronary Patients Regarding Sex Activity?	Viewpoints	II	11	22
Male Genital Abnormalities Which Interfere With Intercourse	L. Wershub	II	9	53
Vasectomy	A. Ferber & W. Ferber	II	6	29
Sex After Prostatectomy	A. Finkle	II	3	40
Should Circumcision Be Done Routinely?	Viewpoints	I	4	26
Oral Contraceptives and Their Effect on Sex Behavior	S. Sturgis	II	1	4
What Emotional Problems in Family Planning Do You Encounter?	Viewpoints	II	9	14
Emotional Bases of Fatigue	J. Trainer	III	1	59
Sex Behavior and the American Class Structure	T. Ferdinand	III	1	34
Some Aspects of Lower Class Sexual Behavior	L. Rainwater	II	2	15
Should Teenagers Be Given the Pill?	Viewpoints	II	2	6
Recently Exploded Sexual Myths	L. Salzman	I	1	6
Some Emerging Sexual Expectations Among Women	R. Bell	I	2	65
What's Sexual Promiscuity?	J. Golden	II	10	47
Sex and the Underaged Girl	C. Scrignar	II	12	34
A Child Has Been Molested	J. Mohr	II	11	43
Homosexual Experience in Adolescence	W. Gadpaille	II	10	29
Homosexuality and the Law	R. Slovenko	I	1	35
Should Homosexual Behavior Between Consenting Adults Be Considered a Crime?	Viewpoints	I	2	39
Sex in Prison	R. Banay	II	4	30
The Effect of Alcohol and Drug Abuse on Sexual Behavior	D. Gallant	II	1	30
Alcohol, Sex and Marriage	J. Ewing	II	6	43
Sex Education	L. Kirkendall	II	5	40
When Children Use Obscene Language	S. Harrison & M. Minshaw	II	12	6
What Is the Effect of TV and Movies on Sexual Attitudes and Behavior?	Viewpoints	II	3	22

C. You may elect to read some of these articles in detail, but you should at least "browse" through some of them.

The Mistress in American Society	J. Cuber	III	9	81
Sex Play Among Boys and Girls	S. Finch	III	9	58
Relationship of Coital Frequency to Sexual Satisfaction	L. Salzman	III	9	6
On Sexual Apathy in the Male	R. Greenson	III	8	25
Sex and Family Life	J. Udry	II	11	66
Sex in Remarriage	J. Bernard	II	10	54
Problems of Widowed, Divorced and Unmarried Women	R. Klemer	III	4	26
Sex for Non-Sexual Reasons	J. Marmor	III	6	8

Title	Author	Vol.	#	Page
Sex and Marital Counseling in Family Planning	M. Goldberg	III	7	94
Impotence as a Reflection of Marital Conflict	J. Lewis	III	6	73
The Executive and His Family	J. Peterson	III	5	6
Hysterectomy and Feeling of Femininity	M. Hollender	III	7	6
The Exhibitionist	J. Mathis	III	6	89
Myths Regarding the Sexual Criminal	R. Sadoff	III	7	64
Symposium: The Treatment of Sexual Offenders	H. Resnik et al.	III	8	35
Answers to Questions	A. Auerback et al.	III	9	45

D. These reference books are not designed to be read cover to cover by the practicing physician. However, they are valuable as a detailed recourse on specific topics about which there is hard research data available.

Kinsey, A. et al.: *Sexual Behavior in the Human Male,* W. B. Saunders Co., 1948.
Kinsey, A. et al.: *Sexual Behavior in the Human Female,* W. B. Saunders Co., 1953.
Gebhard, P. et al.: *Sex Offenders,* Harper & Row, 1965.
Lloyd, C. (Ed.).: *Human Reproduction and Sexual Behavior,* Lea & Febiger, 1964.

E. Most readily available resource materials (films, videotapes, slides, pamphlets):

1. Indiana University Medical Center, Medical Educational Resources Program.
2. Indiana State Board of Health.
3. Social Health Association of Indianapolis and Marion County, 615 N. Alabama Street, Rm. 216, Indianapolis 46204.
4. American Medical Association, 535 N. Dearborn St., Chicago 60610.
5. American Academy of Pediatrics, 1801 Hinman Ave., Evanston 60201.
6. National Education Association, 1201 E. 16th St. N.W., Washington, D. C. 20036.

Group discussions with colleagues, who have recently studied the same material, are extremely valuable. The feedback they provide will help you evaluate your own increasing sophistication. Such discussion may be easier to start or maintain if there are occasionally "expert" guest participants. In addition to the authors in your selected bibliography, a list of the faculty for the 1969 sex education course for I.U. medical students is included.

Don McCallum, M.D.	Urology, Private Practice
Eugene Levitt, Ph.D.	Clinical Psychology, Professor, I.U.M.C.
Jim Elias, Ph.D.	Social Psychology, Research Associate, Institute for Sex Research
Paul Gebhard, Ph.D.	Anthropology, Director of Institute for Sex Research
Charles Echt, M.D.	OB-Gyn, Assistant Professor, I.U.M.C.
Frank Lloyd, M.D.	OB-Gyn, Director of Research, Methodist Hospital
Herschel Moss, M.D.	General Surgery, Private Practice, President of Voluntary Sterilization Association of Indiana
Joe Thompson, M.D.	OB-Gyn, Assistant Professor, I.U.M.C.
John Melin, M.D.	OB-Gyn, Private Practice (part-time faculty)
Harriette Conn, J.D.	Attorney, member of Indiana State Legislature
Ted Mikolon, B.D., M.A.	Minister, Lutheran Church, Child Welfare Association
Paul Muller, M.D.	OB-Gyn, Private Practice
Irving Rosenbaum, M.D.	Pediatrics, Private Practice (part-time faculty)
Ken Lovko, M.D.	Adolescent Psychiatry, Assistant Professor, I.U.M.C.
Betty Jackson, A.B.	Educator, Executive Director of Social Health Association of Indianapolis and Marion County ◄

Aseptic Meningitis

R. RUSSELL MARTIN, M.D.
Indianapolis*

MOST physicians, especially those who treat children and young adults, will encounter patients with aseptic meningitis. In evaluating these patients, the physician must examine all the available evidence to decide whether a benign process requiring only symptomatic therapy is present, or whether there is an infection that should be treated with specific chemotherapy.

Aseptic meningitis is a syndrome caused by a large number of underlying diseases, most of which are infectious. Simply stated, aseptic meningitis is present when there is inflammation of the meninges without bacteria demonstrable by stain or culture of the cerebrospinal fluid (CSF). Clinical signs and symptoms may include headache, fever and meningismus, while the examination of the CSF usually reveals pleocytosis (predominantly mononuclear cells), a moderate protein elevation, and a normal glucose concentration.

Etiologies of aseptic meningitis include: (1) Antibiotic-modified bacterial infection; (2) tuberculosis or fungal infection; (3) self-limiting viral or leptospiral infection; (4) carcinomatosis, lymphoma, leukemia, hypersensitivity reactions, and other varied diseases. The fourth group of miscellaneous problems are rare causes of aseptic meningitis and will not be discussed any further, except to point out that invasion of the minges by neoplastic cells can result in low CSF glucose and simulate chronic meningitis.

It is important to recognize and properly treat the bacterial infections which present as aseptic meningitis. At a referral center such as a university hospital, it is very common for patients to have received antibiotic therapy before the first CSF is obtained for studies. In such a patient, the possibility of inadequately treated bacterial meningitis must be strongly considered, even when the laboratory values indicate an aseptic meningitis. Brain abscess, mastoid infections, and other infections not directly involving the meninges will often cause CSF abnormalities mimicking those of aseptic meningitis. These problems must be suspected on clinical grounds, and appropriate studies will usually confirm or make unlikely the presence of para-meningeal infection.

Fungal Meningitis

Tuberculosis or fungal (especially cryptococcal) meningitis is often recognized because of the more gradual, relatively insidious onset of clinical manifestations. A positive PPD skin test may be an important clue to tuberculosis, while the presence of associated problems (lymphoma, steroid therapy, etc.) may suggest cryptococcal meningitis. Characteristically, the CSF glucose is lowered in chronic, non-bacterial meningitis. However, the glucose depression may not be absolute and may require comparison between blood and CSF glucose for detection. The presence of tuberculosis may be confirmed by culture of the CSF, but therapy with INH, PAS and streptomycin must not be delayed if the clinical course and repeated CSF examinations are consistent with tuberculosis. Repeated india ink preparations and fungus cultures may be necessary to establish the presence of cryptococcal meningitis. Sometimes, cryptococcal infection is documented by growing the yeast from blood, sputum or urine when spinal fluid cultures are not positive. Amphotericin B, given intravenously for a prolonged period, remains the treatment of choice.

The majority of patients with aseptic meningitis will have benign, self-limiting illness requiring only symptomatic therapy. The presence of distinctive clinical features accompanying the meningitis, such as the parotitis of mumps or pleurodynia with Coxsackie infection, may allow a specific agent to be implicated without elaborate laboratory studies.

The season of the year in which aseptic meningitis occurs is extremely important in suggesting the probable etiology. In the winter and spring, mumps, lymphocytic choriomeningitis, and viral exanthems (rubeola, varicella, etc.) are the most important agents. In the summer and fall, aseptic meningitis is very likely to be caused by enterovirus (polio, Coxsackie, ECHO), leptospirosis, or arthropod borne (arbor) encephalitis viruses. Aseptic meningitis due to herpes simplex seems to be sporadic, with occasional cases throughout the year.

Laboratory Studies

The specific etiology of the infection causing the aseptic meningitis may often be determined by laboratory studies available through the State Board of Health. In all of these infections, acute and convalescent sera should be submitted to the laboratory. These specimens are often all that are necessary for the diagnosis of the major winter agents, or for leptospirosis and arbor viruses among the summer-fall group. However, the substantial number of cases due to enterovirus require more elaborate studies. Polio viruses are now rarely responsible for aseptic meningitis, but Coxsackie and ECHO viruses continue to cause many cases during the summer and early fall. Only three antigenically distinct types of polio virus cause clinical disease, so it is

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possible to examine paired sera for antibody increases using stock laboratory antigens. There are more than 60 known different strains of Coxsackie and ECHO viruses, which makes it impractical to set up a battery of serological screening tests for each specimen. Instead, cultures of throat washes, stool, and CSF must be obtained for virus isolation. Acute and convalescent sera are collected for antibody studies. If a virus is cultured, the sera may be tested for the presence of rising titers of neutralizing antibodies against the strain isolated. Since viruses may be cultured from persons free from disease, just isolating a virus does not establish the presence of infection. The isolation of a virus and the detection of increasing antibody levels to the virus make infection likely.

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1. Adair, C. V., Gould, R. L., Smadel, J. E.: Aseptic Meningitis, a disease of diverse etiology: clinical and etiologic studies on 854 cases, *Ann. Int. Med.* 39:675, 1953.
2. Kakulas, B., Adams, R. D.: Viral infections of the nervous system: aseptic meningitis and encephalitis, in *Principles of Internal Medicine*, 5th ed., T. R. Harrison, editor, McGraw-Hill, New York, 1966. ◄

About Our Cover



This month's cover depicts a physician thinking—but more than that he is musing, relaxing, day-dreaming, or reflecting.

How strange such a picture should cover the General Practice issue! Self-pity or not, we in general practice feel reflecting to be antediluvian. In this case, the flood is the deluge of patients with their demands for our service which surely must inundate all general practice in Indiana today.

Reflecting was done long ago, before telephones, emergency rooms, exploding population, records, Medicare, coronary care units, joint commissions, third parties, staff meetings, Medicaid, postgraduate education, lab reports, counseling, and insurance forms. Show me the general practitioner who doesn't feel caught up in an ever-accelerating vortex of duties, who doesn't yearn for the traffic light to redden ahead so that he *may* stop for more time to plan his day.

Contemplation is gone; reflection is a rare art today. If there is time, morning catches the general practitioner staring at his face in his shaving mirror—this physical reflecting may be today's last chance for mental reflecting—wondering if he has been missed at church, club, or home.

Surely the constant rush, the muscle-weakening, bone-fatiguing pressure from incessant changes of attention from one demand to the next must drive more physicians from general practice to specialty than all desires of fame, fortune, and intellect.

Specialists are very busy, but we general practitioners feel that broader patient usage coupled wtih diminishing cohorts, stacks a multitude of little demands much higher than the more limited, less frequent, albeit deeper, demands on the specialist.

If you, Dr. General Practitioner, look upon yourself as the embattled front-line physician and without time for anything but medicine; if you feel this way now, have in the past, or think you will in the future—to you this issue of *The Journal* is dedicated with the hope you find more time for reflecting from this time on.—Alvin J. Haley, M.D., Fort Wayne.



The Case of the Zapista from Durango

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

The most prosaic of phone calls can lead to the strangest cases: as witness Senor Munoz! A very nice widow, residing just around the corner from my co-op apartment, called to ask me to pay a professional visit on her immediate neighbor, as "He seemed very sick." Ordinarily, I contrive to evade such requests. However, I knew the woman; I had the time; I went. The lady guided me to the proper entrance, rang the doorbell and led me in.

The tiny apartment appeared neat and orderly; a bathrobe-covered man was reclining on a bed. As he started to heave himself up, I told him to stay put. The three pillows beneath his head, the gasping respirations, the drum-taut, distended abdomen, the enormous, edema swollen legs—all this was manifest to the most casual first glance. My initial queries had the standard ploy as cardiovascular failure was the obvious diagnosis. Surprisingly, the patient was clear mentally; his ready replies were couched in passable English, heavily flavored with an accent that I could not place.

He had had good health all his 70-odd years; he had not seen a doctor in 20 and more years. He did not know his exact birthday. He had been born in a part of Mexico where exact records had not been kept. After Porfirio Diaz had been overthrown in 1910, there had been a lot of chaos in the state of Durango; there had been much looting and killing. Mr. Munoz had come from a very deprived campesino family; his parents had been murdered by government soldiers. As a totally illiterate, starveling teen-ager, he had joined one of the roving bands of brigands looting the haciendas of the wealthy. For years, it was just unplanned, blurred, struggle for survival. And then: Zapata and his horsemen had swept up north from Morelos to help Villa fight General Pershing's invading Yanqui Army.

I do not remember how we became sidetracked into discussing such details of the Mexican Revolution. I do recall the patient's surprise at a gringo doctor even knowing that particular revolutionary's name. When I asked Munoz as to whether he had been present at the ambush set by Carranza in which the agrarian Zapata was killed—complete rapport was established between us.*

The physical examination started out rather perfunctorily but then became more meticulous: things were not quite what they seemed. True, the heart was maximally enlarged and heaving irregularly at some 160/min. The nondescript murmurs blanketed the entire cycle of systole and diastole. Incipient pulmonary edema was suggested by the tremendous rales and rhonchi in both lungs. However, the liver was, if anything, shrunken. Its edge was hard and nodular. Was it cirrhotic? Was a neoplasm lurking there? And how had he managed to have come to this level of disintegration while still living by himself? The neurological examination yielded nothing really tangible; even the eyegrounds displayed only the venous engorgement in the presence of—maybe—grade two arteriosclerosis.

Tumefacient Temulence

In any case, hospitalization was most urgently indicated. Munoz had

* *Zapata and the Mexican Revolution*, John Womack, Jr., Alfred A. Knopf, Inc., 435 pp., 1969.

insurance; also, he reassured me that he had ample funds. The widow, who had remained in the room all this time, spoke up saying that he always paid in cash and that his checks were unfailingly good. I called a hospital for a reservation; then I phoned for an ambulance. While waiting, I had the patient swing his feet over the edge of the bed; as he swung around, he needed being propped upright. I slipped a spinal puncture needle into his right lower quadrant; this started drainage of the fluid that was ballooning his abdomen and shoving the diaphragm against the embarrassed heart.

While so engaged, we talked some more. What was that large decanter of brandy doing on the coffee table? And how about all those stacks of wine-filled gallon jars and smaller bottles of harder stuff lined up neatly by the side of the couch and under the bed?

"Well, doctor! Whence I come, plain water was considered a dangerous thing! You got cholera, typhoid, worms and all sorts of killer bugs. Even now, I'm sure that you've heard of the turista trots. As a very small boy, I started drinking wine—and tequila, too. How much? As a grown man, I became accustomed to tossing a gallon or so of vino plus, maybe, a fifth of brandy; who counted? Now, I live in Yanqui New York and I am much, much older. I've learned to take some water and even milk. I *think* I drink only a couple of gallons of wine a week—ditto, several fifths of brandy."*

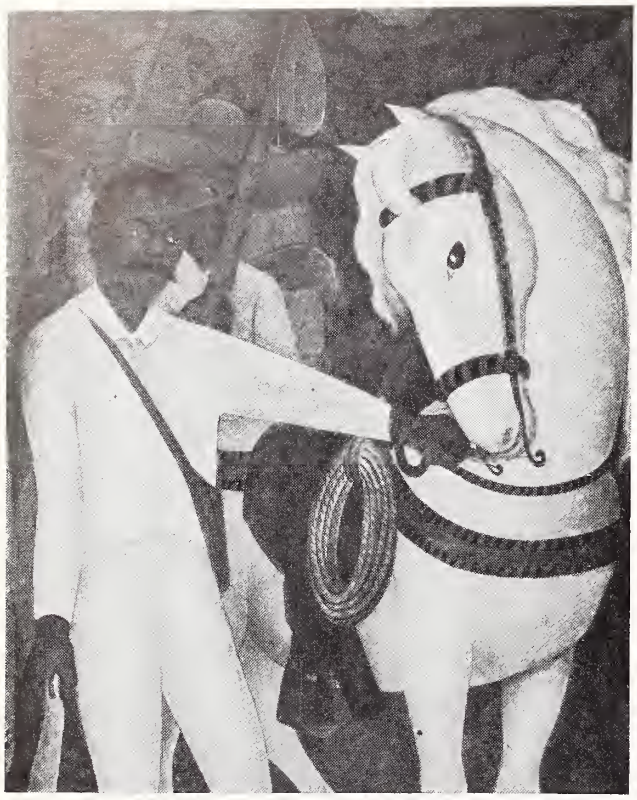


The liquid squirting into the pan was almost crystal clear. Also, the patient had received I.V. 100 cc. of 50% glucose, 0.5 gm. aminophyllin and 15 mgs. of morphine. By the time the ambulance arrived, more than a gallon of ascitic fluid had been drained off. The heart had slowed to some 140/min.; the respirations were ever so much less stertorous: pulmonary edema was being averted.

I called the intern in the Intensive Care Unit alerting him to the peon, muy forte. After supper, I traipsed over to the hospital. Accompanied by the chief resident, I paid a visit to the patient. The busy beaver staff had done an amazing amount of work in the brief hours since his admission. No wonder that these superbly staffed and constantly monitored units are becoming such integral parts of all up-to-date hospitals. The fantastically high initial venous pressure was already beginning to diminish. The sluggish circulation time was also rallying. The water works had failed; a Foley catheter was draining the bladder well. Most of the serum and other body fluids' analyses were unexceptional. Astonishing was the extreme alkalosis (checked repeatedly). A CO_2 reserve in the high 40's can be called only that. Eventually, it was corrected; no one ever did explain the WHY of it being so asymptomatic.

The resident had digitalized Mr. Munoz stat, I.V. His capacity for this pillar of cardiac therapy proved surprisingly meager. The E.K.G. on the oscilloscope was still displaying a horrible, irregular fibrillation at the 140/min. rate with countless PVC's and even occasional bursts of ventricular tachycardia. I gave the patient 200 mgs. of Persantine (dipyridamole) I.V. on the spot. This is a drug whose uses are still in dispute. Purely by a bit of serendipity, I had stumbled on the clinical finding that this

* Purely as an *historical* aside, my older colleagues may recall the turn of the century immigrants from eastern and southern Europe. These people would sew themselves into winter underwear in the fall; in the spring, they would cut themselves out of same. Bathing was a dangerous pastime; water (in any form) was deeply suspect. Beverages were alcoholic; this is still the situation in many of the lands whence these folk came. Tales are many; mostly apocryphal. I have vivid recall of one of my first patients; I had started practice in Gary towards the end of the Hoover Administration. This venerable oldster would cut himself out of the winter underwear just before Easter. Before going to confession, he would actually go to the public bath-house for his annual ablution. So that his heroism should not go by unnoticed, he would boast to me, "Every year, before seeing the priest, *whether I need to or not,* I take a bath . . . ."



THIS mural of Zapata by Rivera is in Cuernavaca.

compound makes possible an effective employment of far larger than usual doses of digitalis.*

Siccative Solutions

Of course, massive doses of diuretics were poured in: Mercuhydrin, furosemide, Aldactone—you name them! As the days passed, the heart began to stabilize. It slowed to a rate of some 100/min.; the bursts of ventricular tachycardia vanished from the screen. The I.V. pronestyl dosage began to be decreased. The waterlogged body weight of over 200 lbs. was diminishing pound by excreted pound. The digitalis dosage was kept at 0.25 mg. digoxin q.i.d.; Persantine orally was maintained at 50 mgs. t.i.d.. The dilated heart gradually shrank to almost normal dimensions. The pulmonary congestion subsided. By the end of the third week, he still needed the indwelling Foley. Our G.U. consultants were "willing to do a prostatectomy—whenever there was medical clearance!" Jolly jokers!

The blood VDRL was negative but, the otherwise normal spinal fluid showed meningovascular lues type curve of colloidal gold studies. Well, this did not bother us unduly as we had given him massive doses of antibiotics just as a routine, prophylactic precaution. We did do a liver biopsy. This showed the CHF plus an only second stage cirrhosis: after all that unheard of ethanol consumption? And how were we to account for the patient having been able to stay so fantastically clear mentally until almost the last possible moment? Was that lurid alkalosis a balancing factor? ?

By the end of another month, the weight flattened out at about 150 lbs; the abdomen was flat; ankle edema was gone; the Foley was out and the bladder functioning almost normally! The lung x-rays showed some pulmonary fibrosis and emphysema. Astrup tests showed about 60% of normal function; well! Two packs of cigarettes daily might have had something to do with that!

Oh, yes. Our Zapatista stalwart did everything as he was told—except for one thing. He insisted on his daily ration of liquor! After prolonged arguments, we allowed him a pint of "medicinal" wine with each meal. As to the tequila—well; I was adamant on "hospital rules." He yielded on that: but only for the duration of his hospital stay!

Some three months went by. The patient was out of bed ad lib.; the digoxin was reduced to b.i.d.; the Persantine, 25 mgs., ditto. The auricular fibrillation persisted even if the heart rate was an almost even nodal rhythm of 70/min.. The results had so exceeded our expectations that we began to toy with the idea of attempting RSR via cardioversion plus cardiac catheterization with a view of later cardiac surgery. . . . However, after soul-searching consultations with eminent colleagues, it was unanimously decided not to tempt the Fates. Our mystifying vaquero turned bracero was sent home as is! I'm still following him there.

Of all that have studied him, no single el medico has been able to explicate the rationale of the individual coming so close to the very brink of death without realizing how sick he was. Just what made it possible for him to perform his daily chores —and stay so perfectly clear mentally?

The widow lady has remained his very close friend and companion. Just the other day, she remarked to me that she was puzzled anent his Mexican origins. "Everybody around here had been told by Mr. Munoz that he had come from Puerto Rico . . . ." The next visit around, I taxed Mr. Munoz with this tidbit. His riposte was a smirk of self satisfaction —and some further confidences.

Mafiosi, Mayhem, Mexico

"Well, doctor! After Zapata was bumped off, many of us followed Villa. Then, several years later, the big shots got him killed, too. After *that* set-to, some of the survivors—those who were of no mind to go back to

*1. Lieberman, A., Guglielmelli: Persantine, a Double Blind Study, *Angiology* 15:290-292, 1964.

2. *The Pharmacological Basis of Therapeutics*, Goodman & Gilman, 3d ed., sec. 15, p. 745, 1965.

3. Disease of the Month, Sept., 1964.

their home villages—became smugglers, plain cattle rustlers: a fast buck and an even faster death! A couple of my buddies got tangled in the woman and dope traffic. The Mafiosi made contact with our band: you know their methods? Good! What with their contacts on the American side of the borders things were made easy for us and we were well paid.

"It's a long tale! Anyway, we pulled off a really big job; we were due to get almost a million of your American dollars. . . . We had a rendezvous at a certain ranch just on the Texas side of the border. I was having a little flirtation with a maid at that place; she told me some things that made me mucho suspicious—you've heard of their double-crossing ways; I don't have to draw pictures. I was sure we were slated for a burst from their Chicago pianos; oh, you've heard of them, too? After 15 years of practice, I was not too bad with them myself.

"We went, all right, but in two groups: the captain and three others (including me) as the back-up surprise. The first bunch were effusively received, wined and dined—and gunned down: without a chance ot draw! But our four were lurking at the windows—well hidden . . . . WE burst in and gunned *them* down. I counted 17 dead Sicilianos! Only the captain and I were alive in that big house. We searched it—but carefully!

"So! The loot was loaded on several burros and horses. We snuck back to Mexico before daylight. We made tracks—fast tracks away into the mountains, south and west. There was no one left alive who knew our camouflaged cave. We lurked there a bit, just going to the village for supplies when needed.

"However, Al Capone and his capos were known for their long reach and never-fading memories.



Also, of what use was all that wealth to us hiding in our cave? The more we talked about it, the more we knew that we had to get a *long* distance away—and become altogether different people!

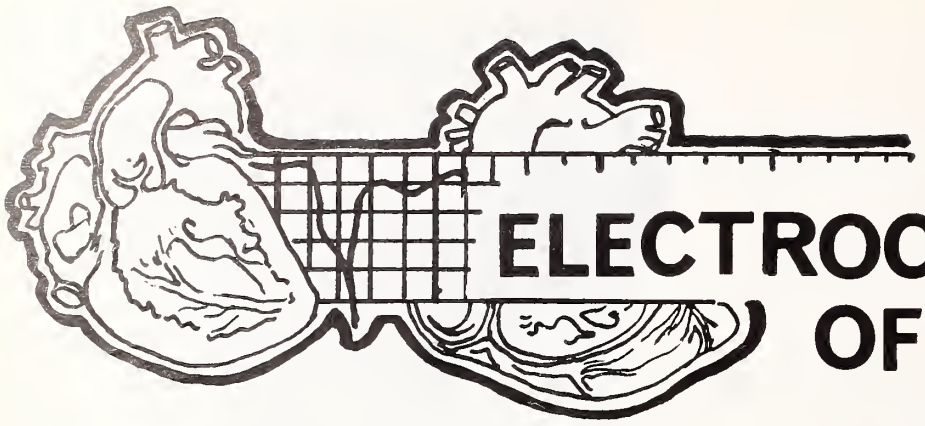
"We traveled by night as shabbily dressed, ever so miserable charcoal burning peons. We drifted west and south. We got to Morelos and then Yucatan. We managed a boat to Colombia. From there we paid our way to Puerto Rico as natives who had been shanghaied FROM Ponce! In that town, we holed up in the favela. We could *buy* new birth certificates with new names. After a bit, we shipped to NYC; here we split the swag and separated, each going his way. I still had dough unbelievable—if I could just stay away from the long arm of the Mafia with their horrible omerta.

"I was hungry for a good life: ease, comfort, a good woman, study, knowledge—everything I had not tasted. The money I was able to stash in safety vaults; eventually, I even opened some bank accounts. I got me a job of sorts so that people would not wonder how I was making a living. I was a complete nonentity with only the minimal neighbor contacts in a Spanish-speaking neighborhood.

"So, here I am! Why do I tell you all this? Well, the guys who wanted me dead are dead themselves—oh, this I know. The Siciliano 'Families' have more important jobs for their guns today. I *like* you—some day you may even write me up; of course, I know you medicos don't understand me. This may give you more background!"

So, there you are! My *Zapatista from Durango* continues his imperturbable way. He still fascinates all his attendings. When I call on him, he offers me his finest liquors. I take a drink; naturally, I do not have his bottomless capacity. Who does? Someday, maybe, I or my colleagues will have the opportunity of doing an autopsy and thus writing finis. Until then? ◄

1270 Fifth Ave.
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ELECTROCARDIOGRAM OF THE MONTH

Myocardial Infarction: A-V Block

CHARLES FISCH, M.D.
*Indianapolis**

MYOCARDIAL infarction may be complicated by varying degrees of A-V conduction delay. A common form of A-V block is second degree block in which some, but not all, P waves are conducted. It is important from a prognostic and treatment standpoint to be certain whether the A-V block is of the type I (Wenckebach) or Type II (Mobitz.) The former is recognized by a gradual prolongation of the P-R interval followed by a dropped beat. In Type II (Mobitz) there is no prolongation of the P-R but a sudden and unexpected failure of conduction. The former (Type I) is seen with inferior (posterior) infarcts and carries a good prognosis, rarely requiring pacing. Mobitz II, on the other hand, is uncommon, usually complicates extensive anterior infarction, carries a guarded prognosis and should be treated with artificial pacemakers.

Figure 1 is an example of Wenckebach (Type I) A-V block. The control (4-16-69) shows the acute injury of infarction. Tracings on 4-17-69 demonstrate the Wenckebach structure with 3:2, 4:5 and 5:6 A-V block in rows 2, 3 and 4 respectively. Spontaneous establishment of normal sinus rhythm is recorded on 4-20-69.

Figure 2 is an example of Mobitz II second degree A-V block. Without any prior change in duration of the P-R interval, the P fails to conduct. In the top row the pause following the nonconducted P is terminated by a ventricular premature systole.◀

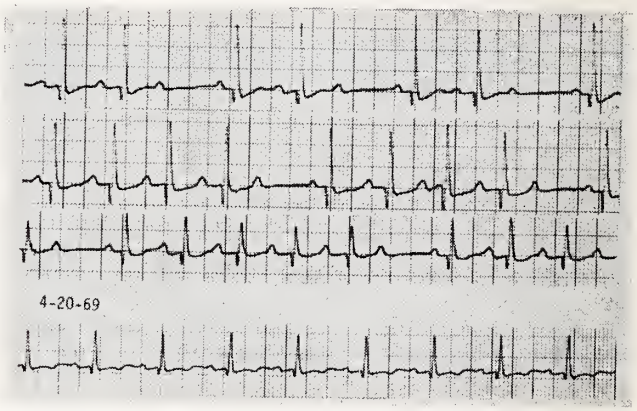


FIGURE 1
WENCKEBACH A-V block.

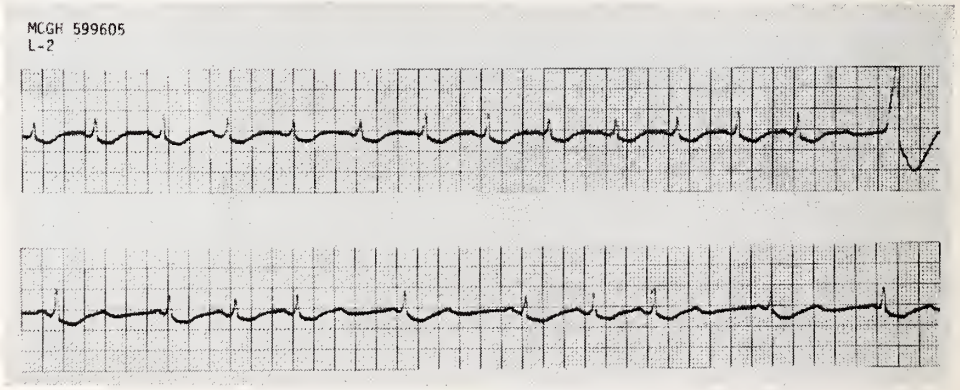


FIGURE 2
MOBITZ (Type II) A-V block.

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

John Blake thought safety belts were a drag.

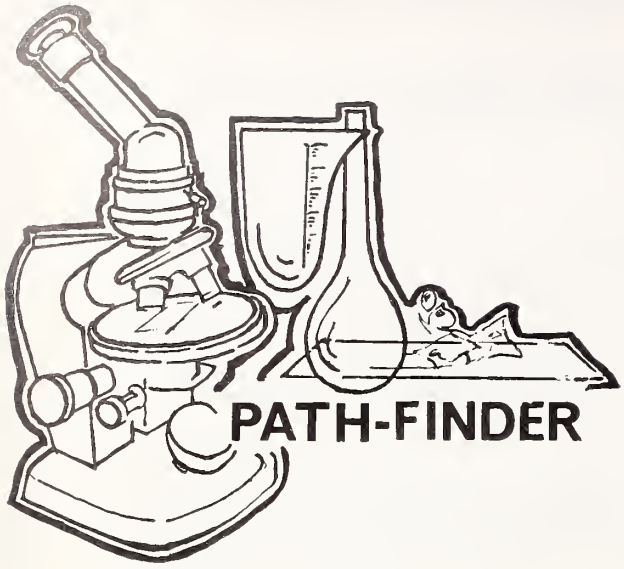


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This series is intended to emphasize the importance of judicious selection and proper interpretation of newer laboratory procedures as applied to differential diagnosis of various diseases. It is edited by Leon L. Blum, M.D., Terre Haute.

Platelet Transfusion

ARTHUR C. JAY, M.D.
*Muncie**

PLATELET transfusions are often necessary in the therapy of patients with thrombocytopenia. Thrombocytopenia may be acute as in leukemias, in bone marrow depression due to chemotherapy, in overwhelming infections, or in intravascular coagulation syndromes. Chronic thrombocytopenic states include aplastic anemias, and idiopathic, or immunological thrombocytopenias.

Platelet therapy depends on several factors, including clinical evaluation of the patient, the cause of the thrombocytopenia, the platelet count, the clot retraction test, and the relative risks of hemorrhage in the patient with thrombocytopenia of various degrees.

The degrees of thrombocytopenia are defined as, 1) severe thrombocytopenia with a platelet count below 10,000 per cu. mm. of blood in which the patient may need platelets, although the platelet deficiency in patients with aplastic anemia, or idiopathic and immunological thrombocytopenias may not be corrected by platelet transfusions. 2) Moderate thrombocytopenia (10,000 - 30,000 per cu. mm.) usually will not require platelet transfusions, but these patients must be watched closely. 3) Mild thrombocytopenia (30,000 - 100,000 per cu. mm.) does not require platelets unless surgery is imminent, and then the platelet count should be over 100,000 per cu. mm. However, patients with either mild or moderate thrombocytopenia who have evidence of hemorrhage may need platelets.

The types of platelet transfusions include fresh whole blood, fresh platelet rich packed red cells, platelet rich plasma, and platelet concentrates. The latter two are the most economical, efficient, and specific forms of therapy. Platelet rich plasma contains about 90% of the platelets from a unit of fresh whole blood in a volume of 220 ml. of plasma. Platelet concentrates are the best form of therapy for patients who need restriction of the volume of transfusion. This includes pediatric patients and some with cardiovascular or renal diseases. About 70 - 80% of the platelets from a whole unit can be given in 25 ml. of plasma transfusions.

The number of platelets needed may be calculated on the basis of the platelet count, the body area, the age of the platelets, and the clinical response of the patient. One unit of fresh platelet rich plasma should raise the platelet count 12,000 - 15,000 per cu. mm. one hour after infusion in a patient with one square meter of body surface area.

The donor blood used as the source of platelets should be no more than six hours old. It must be compatible with the ABO, and Rh antigens of the patients. The blood bank should be informed as early as possible of the impending need for platelets. This is especially true of patients with blood groups B or AB. For the best possible service to the patient, there should be close cooperation between the clinician and the blood bank personnel. ◄

* From Pathologists Associated, Ball Memorial Hospital, Muncie.



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Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia,* exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

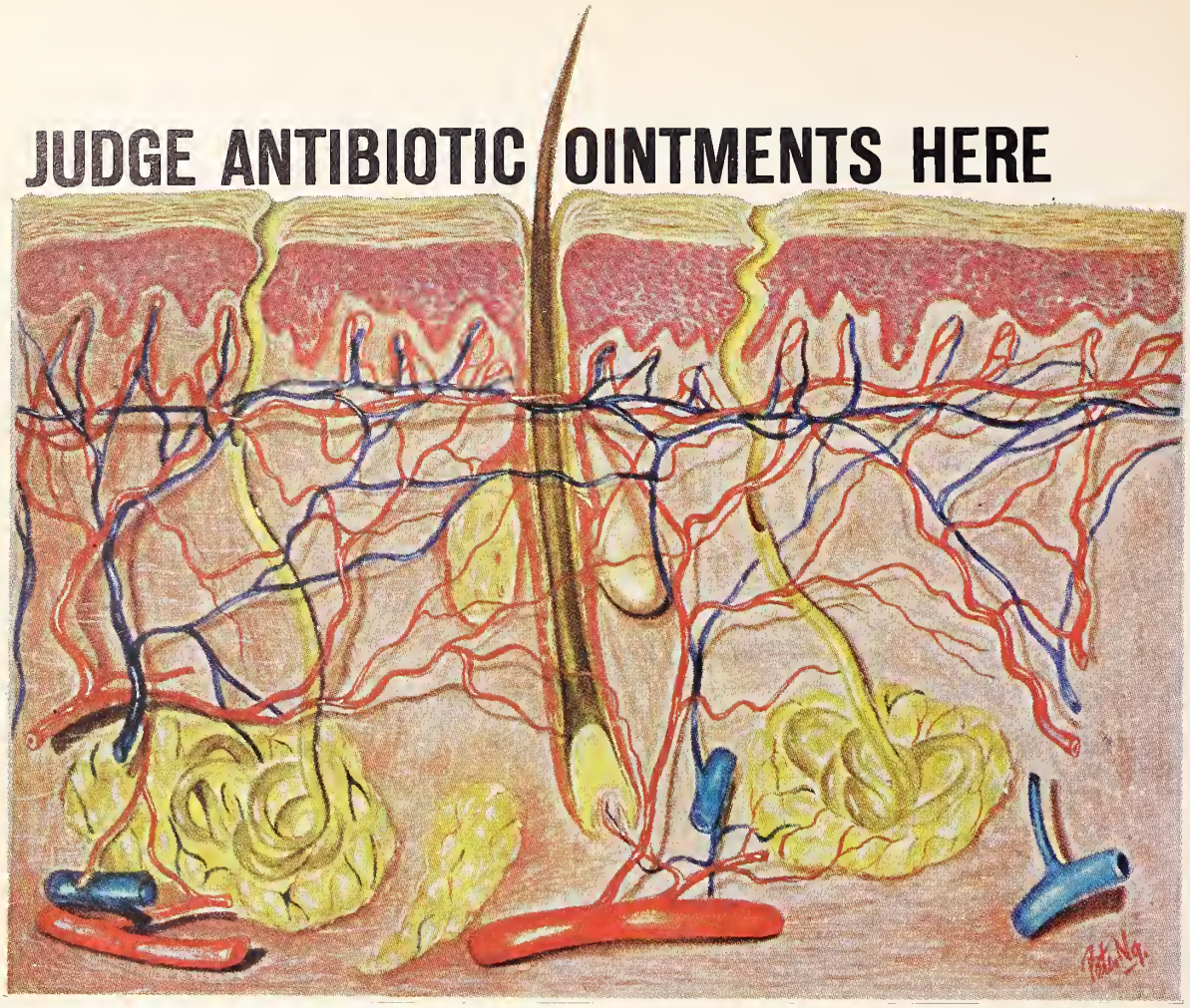
Dosage Forms: Oral tablets . . . 250 mg.
Vaginal inserts . . 500 mg.

*References available on request.

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The Columbus Story

STATE medical journals, including this journal, received a high rating in a recent report of physician interest and disinterest in 14 medical publications.

A series of over 400 personal interviews, carefully designed to eliminate bias and partiality, shows that:

1. The state journal is at least third in reading interest when compared to the 13 major nationally circulated medical magazines and journals.
2. Not more than one in seven fully-active physicians expresses reading DISinterest in his state journal.
3. In a "choose 3" type of question, the state journal is chosen more often than nine out of 14 publications.

To secure a true random sample, the interviews were spread over nine states and were conducted exclusively in cities named Columbus or Columbia, and in one Columbia County.

In areas with fewer than 50 physicians, interviews were sought with every practicing doctor. In each of the four largest "Columbuses," 70 physicians, chosen by random sample, were interviewed.

The nation's "Columbuses" provided a unique sample of the national physician audience. Communities bearing the great explorer's name vary in size in this survey from 7117 to 540,000. The ten cities are located north, south, east, and Midwest. (Far western states were not included). The variations also include industrial regions, agricultural areas, and communities so general in nature as to be unclassifiable. Two of the larger cities contain medical schools. Others have small colleges. A few are rural in nature.

The final score is a compilation and average of the total interviews. However, practically the same findings were achieved in each of the ten cities. Doctors everywhere were uniformly loyal to and enthusiastic about their state journal.

This widespread and uniform interest indicates that state journals are a vital part of the practice of medicine and postgraduate education. All specialty journals were excluded from the survey, but of the 13 national journals, only two scored as well as the state journals.

Repeal of Antisubstitution Laws

THE American Pharmaceutical Association, at its recent annual meeting, passed a resolution in favor of repealing pharmaceutical antisubstitution laws.

Almost all the states have either statutory or regulatory provisions which prohibit a pharmacist from varying from the intent of a prescription without the knowledge and permission of the prescriber.

The reasons behind an attempt to void a beneficial regulation of long standing are simply not understandable, especially when it originates from one of the policy-making bodies of a profession which is noted for its dedication to high standards of care in the handling and use of drugs.

Even more difficult to understand is the APhA argument that "repeal of the antisubstitution laws would not disturb the existing prescriber-pharmacist relationship or deprive the prescriber of the right to insist that a particular product be dispensed." It seems apparent that the antisubstitution laws guarantee the right of the prescriber to expect that a particular product will be dispensed, and that repeal would remove this right.

Despite the high quality of a great many drug products, it is evident that there are prescription drugs in commerce in the United States that are not up to proper standards. The Department of Defense has an agency which inspects pharmaceutical manufacturers and their products. The government buys products which are certified by this agency as qualita-

tively adequate. Out of every 100 plants inspected, about 45 fail to meet standards. Of the 55 which do meet the plant standards, almost half the products produced are not acceptable to the department.

Thus, on quality alone, physicians should be assured that the product written is the product which the patient receives. However, it is well known that pharmaceuticals of the highest quality will vary in biological availability due to different types of formulation in manufacture. When a physician is acquainted with the biological availability of a certain formulation of an active drug he will base his dosage schedule on this information. Substitution of even a high quality form of the same drug with a different formulation may disturb the pharmaceutical action by a significant degree.

It has been pointed out that the philosophy of a hospital formulary is on an entirely different basis. When a hospital pharmacist dispenses a standard preparation for a variety of requests, he dispenses a drug form which has been chosen and approved by a pharmacy committee. The hospital patient is seen daily and drug actions and reactions may be assessed. Opening up prescription filling to a host of variable preparations and possible inferior products for patients who are not seen every day is a different story entirely.

No possible advantage for repeal could be imagined which would outweigh the many advantages of present antisubstitution laws. The attempt to repeal such laws is evil and ill-considered.

Guest Editorials

Raise the Standard of Fees

Editor's Note: The following editorial is a reprint from the January, 1903, *Fort Wayne Medical Journal-Magazine*. It was written by Albert E. Bulson, Jr., M.D., who was Managing Editor of the *Journal-Magazine*. We are indebted to the *Bulletin of the Fort Wayne Medical Society* who gave permission for the editorial to be reprinted.

Within recent years we have noted the enhanced prices of the necessities of life and the steady increase in the earnings of nearly all classes of people from the modest day laborer to the president of large corporations. With this era of prosperity for the majority of people has not come an increased prosperity for the physicians, except in the fact that in general the medical man is able to collect a larger percentage of his fees than ever before if he is a sufficiently good business man to take advantage of the increased ability of patrons to pay. As a matter of justice to the physician he should receive his share of the prosperity, over and above the mere increase of collections which applies to other lines of business as well as to the practice of medicine. While it costs the physician very much more to live than it ever did before, and while his patrons can afford to pay much more for medical services than ever before, yet in all probability, without exception, the fees for medical services are as low if not lower than they have been in many years. This is a condition which should not exist, and is an injustice which should be remedied by concerted action on the part of the medical profession. This is an era in which combination of forces brings about results not to be obtained in any other way, and consequently there is scarcely a trade, a profession or an occupation in any walk of life that is not dominated and influenced by a combination in the form of a union, a company, a trust, or some such organization having as its object an increase in emoluments. While we do not advocate the formation of an organization among physicians which can be delegated as a "doctors' union," or a "doctors' trust," yet we believe in concerted action on the part of physicians to effect an increase in fees to correspond with the general increase in the cost of living as well as the cost of labor in other walks of life. This increase in medical fees should begin with the general practitioner, who for the most part always has been the poorest paid for services rendered, and yet because of the nature of his services should be one of the best paid. There is no valid reason to be offered in opposition to the statement that medical fees should be increased in proportion to the increase in earnings in other occupations, and we sincerely hope that the matter will receive consideration at the hands of physicians individually if not collectively.

A Greater Force Than Violence

EARLHAM COLLEGE students were probably just as shocked and outraged by the shooting of four Kent State students as any other members of their generation. But they were also affected by some of the violent and radical *student* protests that were occurring across the country.

And their response to *all* of this violent and polarizing discord was the formation of a far-reaching program to, not only promote political responsibility among students, but also increase understanding between Earlham students and the non-academic, adult community of Richmond, Indiana.

Two hundred Earlham students went to Washington to talk with the senators and congressmen from Indiana, while others initiated meetings with community leaders, police officials, businessmen, blue-collar workers and individual citizens in Richmond.

These meetings have led to others and to a growing dialogue between the generations in that city. Students are now riding in patrol cars with local policemen as they learn about the problems of maintaining

law and order. They are receiving and accepting invitations to speak to church groups and service clubs. They're surveying community needs and even becoming involved in efforts to deal with community problems.

We at WFBM are quite impressed with what's happening in Richmond. And we're beginning to find similar activities in *other* college towns—in Indiana and elsewhere in the nation. This week NBC even reported a dialogue going on between some Pace College students and militant construction workers in New York City.

All of this student-inspired activity, we believe, *has* to be encouraged.

Not all of it may be productive. And merely in trying to *do* some things—even while working *within* the system—the students, with their desire to bring about change, are going to antagonize some people.

But these efforts by the Earlham College students, and many other young people, are a good omen for the future. They set a highly positive example for all of us. They're getting a lot of people—young and old—out of that rut of talking only to persons with whom they agree. And, in the long run, we believe this approach can be a greater force for progress than all the violent protest that's come before.—**WFBM Editorial.**

So You Married A Doctor*

"MEDICINE is a demanding mistress," said Sir William Osler. He chose his words with his usual discernment. This truth invariably comes as a shock to a doctor and his bride. To begin with let's look at the kind of man you chose to share your joys and burdens. This man is of a highly select group in the population. His IQ is high, averaging 125. He is high in drive, in energy and in motivation; he has an unusual ability to analyze and solve problems.

With these attributes this man becomes an individual holding a societal status just behind that of a justice of the Supreme Court. He is a high income earner largely because he was willing to make an extraordinary commitment both to his training and to his work. The doctor is a public man, a highly privileged and esteemed person who holds such usable keys as there are to happiness, health and life itself. For him society nullifies its rules and gives him freedom of action matched only by the responsibilities he assumes. How can a wife manage to live around such a ponderous image? From a purely theoretical point of view marriage to such a paragon seems a near impossibility. If the characteristics of the wives of the doctors were not so closely matched themselves, it would be unmitigated disaster!

The Basic Family Pattern

Whether the marriage begins before medical school, at internship or residency a common pattern is evident. The school, the hospital, the practice, sustains the No. 1 position in the life of the doctor. The wife, and later the children, are firmly placed in the No. 2 spot. This tends to persist as a habit pattern of living. It does a great deal of mischief. The divorce rate is smaller than average, but the overall quality is not high. The five most easily distinguishable kinds of relationships are described with great insight by John Cuber who began professional marriage counseling in this country.

The conflict habituated marriage

The couple establishes an early pattern of conflict and keeps it up as a way of living. Each subject becomes a contest or duel.

The passive-congenial marriage

The couple married to be married and never have either a warm or a conflicting relationship. These people are the mainstem of civic activities.

The devitalized marriage

This is the great mass of marriage, revolving around maintenance of a house, raising children and no longer having anything to say to each other.

Vital marriage

This is one in which the pair manages to meet most of the other's needs. They are often relatively nonsocial and looked upon with suspicion.

Total marriage

The couple are entirely wrapped up in each other, tending to appear anti-social. They are usually actively disliked by their cohorts.

What are some of the special personality difficulties characteristic of doctors? There are three which can play havoc in the marital picture.

Communication failure. Men as a group have more trouble with this than women. Women talk more, faster, longer and better than men. One of the cultural stereotypes links strength with silence. Professionally, the doctor has to be careful of any warm expressions because it tends to draw patients in too close to his professional image shield. So the doctor necessarily learns to wear the cloak of detachment. He is often too quiet at home for his wife's comfort.

Conflict-avoidance. The doctor is unaccustomed to sustaining conflict. In contact with other doctors, differences of opinion are minimized, amounting to a kind of professional etiquette. Where conflict arises with his patient, he seeks either a quick resolution of it or quickly suggests the patient get himself another doctor. This habit pattern carried over to the home tends to produce equally

* This article is based on an address delivered at the AMA Women's Auxiliary Fall Conference, September, 1968, by Joseph B. Trainer, M.D.

long-term smoldering conflict which is very destructive.

Smothered dependency need. Few things annoy a woman more than to meet a man who is happy and independent and doesn't need her. This sounds like the appearance of most of the doctors. It is an erroneous view. Within the image of the doctor dwells the mere man. The endless patients heap upon this image their lives, cares, problems and diseases. He bears a vast burden alone. The little boy who had to tell his mother his problems has grown to be a doctor. He ought to be able to tell his wife—but he rarely can. So he has what the psychiatrists recognize as an unmet dependency need.

Here are some tragic facts. Doctors form the largest single group of hard narcotic users, and one of the largest groups of habitual users of amphetamines and barbiturates. Doctors form one of the largest groups of professional people suffering from chronic alcoholism. They are often hard drinkers. Suicide appears to be an extraordinarily high risk for the doctor. A better ability to express their dependency need, and to have it truly met—preferably by their mates—would surely make a drastic reduction in those cold statistics of personal tragedy. How fares the doctor's wife? Because the doctor has difficulty in communicating his feelings the wife tends to lack feelings of worth in the face of the ever-present though erroneous—doctor image. She tends to misinterpret his inability to communicate as his self-superiority. So she feels left out and unwanted. At the same time she is aware of the fact that she has had to undertake a major portion of the management of the home. Because of the similarity of personality types between doctors and their wives, the wife has the individual strength equal to her daily tasks. She herself is an unusually able person. Frequently, before her marriage, she was an unusual accomplisher herself. She then requires something in the way of an achievement beyond that of wife, or mother. The wife and children are very apt to be both physically and mentally poorly cared for. The effects of this on the doctor's wife are much like those on the doctor himself. Admissions to mental hospitals are about twice as frequent among doctor's wives as in the comparable middle-class segment of the population as a whole. Most of these unhealthy, unpleasant characteristics can be remedied. With all its hazards, a medical marriage can still be a good one. Each of us has the power to change that within ourselves which is destructive to the wholeness of marriage. We change when we show to the other persistent and continuing interest, concern and understanding. Husbands and wives, if the marriage is to be truly successful, must meet each other's needs for attention, approval and love. Each partner must be the guardian of the dignity and the privacy of the other. Only if we are conscious of these things can they come to pass. But if we bring them to pass, we will have achieved the head-to-head intimacy that was so briefly ours in the courting year.—*Connecticut Medicine* 34:293-295, April, 1970. **Reprinted with permission.**

How to Relax

1. Just remember that experts say that relaxation is not the same as laziness even though your wife can't tell the difference.
2. To discover the reasons for your tension, think carefully about your living habits. Unless, of course, it *is* your living habits that are making you nervous.
3. Try not to read or listen to anything that brings on tension. This includes the newspaper, television, radio and your boss. In six months time, with our advice, you can become the least-informed, unemployed man in America.
4. Have you set aside enough time for recreation?
5. Have you set aside too much time for recreation?
6. It is usually not feasible to put the children up for adoption, but have you considered long visits to doting relatives?
7. You can't get rid of a mother-in-law that way either.
8. Fill in the appropriate name and then say this to yourself every single morning: "I will not worry about
getting elected or relected President of the United States in 1972."
9. If your job is making you nervous, have you considered Unemployment Compensation as a career? The hours are terrific.
10. If you do become tense, despite all of our good advice, write a nasty letter to *Printers' Shopper*. A great multitude of our readers tell us this makes them feel lots better about anything.—*Printers' Shopper*, 6:2, May, 1970.

Editorial Notes . . .

***U.S. News and World Report* in its January 19 issue compares the advance in physician's fees of 37.8% during the past five years with the advances in auto insurance (38.1%), mortgage insurance (39.2%), household workers (44.7%), and haircuts (32.9%).**

The latest HEW figures show that physicians are now receiving 10.9% of the total expenditure for medicare and medicaid. Inpatient hospital care amounts to 39.8% and nursing home care totals 30.3%.

Every state has a provision in its state food and drug act which is patterned after the Federal Food, Drug and Cosmetic Act in specifying substitution of ingredients as a means of adulter-

ating a product. Forty-eight states specifically prohibit brand-name substitution by statute, Board of Pharmacy regulation, or both. Up to now these laws have been considered as rational—they guarantee that the patient gets what the doctor ordered. Now, believe it or not, there is considerable opinion (some of it highly placed) in the American Pharmaceutical Association, in favor of repealing such laws and regulations. The move to authorize the pharmacist to shift the ingredients of a prescription up or down or sideways apparently is in the interest of economy, on the mistaken theory that economy is highly important—dependability is not.

A screening test for infectious hepatitis would be most helpful. A three-year study of such screening tests will be done by New York University Medical Center under a grant of $238,186 from the Hartford Foundation. Hepatitis is the major problem of blood transfusion. It is estimated that 30,000 cases occur annually, with a fatality rate of up to 12%. Cardiovascular surgery patients are especially at risk since they receive blood from many donors—about four percent to five percent of them develop hepatitis. Another study will be conducted at the same time—"hyperimmune" globulin prepared from plasma from hepatitis convalescents will be used in a control group of these patients to evaluate its effectiveness against the possible occurrence of hepatitis.

Drug abuse is becoming a problem in industry. Maybe one reason it is a problem is indicated by a question asked as a part of the promotion for a recent symposium on "Drug Abuse in Industry." The telltale question was "Does industry have the right to examine new employees for drug abuse?" If anyone in industry is in doubt as to the answer or thinks that the subject is open to debate, there is more than one drug abuse problem.

Medical malpractice suits are less numerous in Canada and England than in the United States. The possibility has been suggested that this is due to the fact that contingent fees for lawyers, at least for this type of litigation, are not legal in Canada and England. It seems that the American lawyers do not favor this intimation of cause and effect. *Trial*, the publication of the American Trial Lawyers Association, contains an article which defends the contingent fee system by suggesting that it protects the doctor from unfounded or weak malpractice claims. The theory is that a lawyer will not invest his own money in preparation unless he thinks the suit is justified. This does not take into account the well-known fact that many unjustified nuisance type cases are "prepared" with scare tactics and little expense and are then settled out of court for a few thousand to avoid heavy trial expenses and embarrassment for the doctor. The "Trial Lawyers" explanation also does not account for the fact that Canadians and English do not have as many suits, by far.

The Los Angeles County Medical Association and the Hartford Insurance Group have arranged a professional liability coverage for physicians under a new group insurance concept. The basic contract provides basic protection. More extensive coverage is available on an individual basis. There is a provision for retroactive sharing of profits and also a special claims handling arrangement. The rating program for the plan takes into account the income that Hartford will derive from investing the premiums it collects and sets up as reserves.

The Carnegie Corporation has made a grant of $150,000 to the Denver Health Research Foundation to finance continued development of a new computer system to handle medical records of the more than 100,000 patients cared for each year by the Denver Department of Health and Hospitals. This grant is secondary to a similar award of $140,000 in 1968 which funded the preliminary studies, which included basic design and studies of patient information, chart movement, patient mobility and legal considerations concerning privacy and confidentiality.

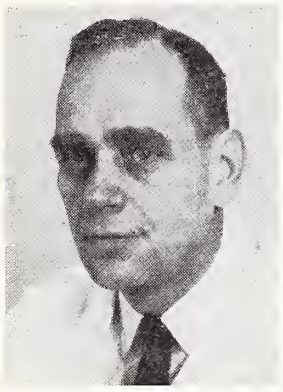
The use of deep wells for disposal of liquid wastes has created some problems and also some doubts as to this plan's advisability. Questions of contamination of underground water sources and mineral deposits have arisen. A few of the wells under use have "blown their top" and discharged the unwanted liquid on the surface and into surface waterways. Dr. Edward J. Cleary, consulting engineer and adjunct professor of environmental health at the University of Cincinnati Medical Center suggests that the process be called waste "storage," rather than "disposal." With the exception of short-lived isotopes and acids that are neutralized by rock formations, the liquid wastes in question are usually highly toxic and remain so in storage.

Federal Court action recently denied the Upjohn Company a judicial hearing on the FDA ruling which has removed Panalba from the market. The fact that the panel of scientists which recommended this action to FDA could not possibly have had the time in which to conduct clinical trials of the drug in question produces an inescapable conclusion that the panel ruled on the drug on the basis of bias, prejudice and hearsay testimony. No court in the land would allow a verdict on such a foundation. If the government can produce evidence that the drug is ineffective or dangerous, it should be ready, willing and able to produce it in court.◄

Bottlenecks in the Development of Health Care Systems*

EUGENE A. STEAD, Jr., M.D.
Durham, North Carolina**

THE American people believe they are entitled to personal health services of high quality which are delivered conveniently and efficiently. Every person in our country is entitled to these services, regardless of his place of residence or of his level of income. The health professionals have agreed that the people are right and that they, the health professionals, have the obligation to deliver the services.



Under present conditions, the entitlement of all persons to personal health services of a high quality is an empty one. The demand for health services far exceeds the supply, and the cost is rising without a corresponding increase in the quantity and quality of services. Let us consider the bottlenecks which must be removed or circumvented before our performance can match the promises.

Our first need is to define the product which we expect to deliver. What are high-quality, convenient and efficient health services? What trade-offs are we prepared to make between quality, convenience, availability and cost? What amount of money are we willing to spend for preventive care? In rural areas and the inner cities, quality of housing, schooling, transportation, nutrition, air and water may be limiting factors in health. Can effective health services be given without changing the environment of many of our people? Without population control, can we ever overcome our deficits in environmental control, in facilities and in trained manpower? We must define the entitlement which the people have, and make clear the advantages and disadvantages of the limits which will have to be imposed to make the goal of universal personal health services possible.

Monopolistic Control

In order to deliver personalized health services to all the people, we will have to devise new institutional forms. The medical schools, nursing schools, and state licensing boards have complete control of the flow of doctors and nurses into the health care field. They have a monopolistic control of essential health manpower. In the past, these institutions have been self-regulated. The interest of the public demands that these institutions relate more closely to the needs of society.

The producers of essential health manpower will have to accept regulation in the public interest, just as have the electric power, communication, and transportation industries.

New institutional forms will have to be developed to marry the public and private funds necessary to finance the development of universal personal health services. Fee-for-service cannot be the only method of payment. There must be more than one form of health service available to preserve the advantages of competition. The private insurance industry has a large stake in health services, and this must be increased rather than eliminated. These institutions have to be developed by persons knowledgeable about the feelings and prejudices of sick and well patients.

The health field will be penalized unless our legislators make available the necessary funds for developmental research at several levels. We must properly distribute our resources to produce trained manpower (education), the delivery of health services (the medicine of today), and biomedical research (the medicine of tomorrow). Atrophy of any one of these areas will penalize tomorrow's society. We need a National Academy of Medicine to continually review alternative programs and to be certain that we do choose the best set of alternatives. We have yet to develop a National Academy of Medicine.

Health manpower is a real bottleneck in the delivery of personal health services to all the people. We do not have enough doctors, and we have no plans to produce enough. We have another equally serious problem. We do not admit into our schools persons with a broad enough array of talents to provide leadership in many areas of the health field. Our medical students must have aptitude in the biosciences or be willing to spend two years memorizing bioscience facts. These requirements keep out of medical school those students with high achievements in the information and social sciences, engineering, economics and business administration. The students who have real talents in these fields simply avoid the medical school. We are going to sorely need persons with these talents as we revise our institutional

* The first Regenstrief Lecture on Health Care, presented at the Marion County General Hospital, Indianapolis, Jan. 27, 1970.

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forms and are required to deliver more units of health care per doctor.

A "Common Mold"

The health professions are handicapped by the fact that the doctors are drawn from a relatively narrow segment of our society. Poor people and minority groups supply few doctors. All American-trained doctors have a common set of experiences. They go to college, they have four years in medical school, they serve two years in the military service, and they have from one to seven years of residency training. These experiences tend to make all doctors fit into a common mold. The professionalization is so strong that they tend to lose much of their original cultural and ethnic characteristics. We need to train a portion of our health professionals without withdrawing them completely from the culture of the people they will serve. We need to mix work and education into a continuum which will allow a larger part of the education to be carried out in the area where the student has grown and developed. Money invested to send students from non-conventional backgrounds to conventional schools will produce our present product and will not affect the distribution of doctors.

Doctors need to organize their practice to produce more units of service per unit of time. This is going to require development of more effective clinical support systems. These will be constructed by better planning of physical units, by increased use of automation and computers, and by the introduction of new categories of trained manpower. Time and motion studies, increased use of system engineering to obtain the best use of men and machines, use of computers for information storage and retrieval, and better business management offer great promise for the future. There will be no major changes in these areas until the medical schools produce the necessary manpower. No medical school has yet converted itself into a university laboratory for development of the interface manpower necessary to man the projects we now dream about.

In the short range, we can move more rapidly by developing the main component of the system to support the doctor. Duke Medical Center is now training assistants who are selected by doctors, who are trained by doctors, and who report administratively directly to the doctor. The trainees are selected because they enjoy the health field, can tolerate the irrationality of sick people, and have a rapid rate of learning. They work with the doctor in the office, in the home, in the nursing home, and in the hospital. Under the doctor's supervision, the assistant does many of the things which formerly have been done by doctors. The doctor and his assistant can produce from one-and-a-half to two times the units of service previously produced by the doctor alone, with no sacrifice in quality.

Summary

In summary, we believe that the American people will be disappointed in their entitlement to personal health services unless the following things can be accomplished:

1. The limits of the entitlement are defined and proper trade-offs are made in quality, quantity, convenience, preventive services and cost.

2. New institutional forms are developed to regulate the flow of health manpower.

3. A National Academy of Medicine is established to continually review the priorities between immediate and long-range needs in the health field. Research in the methods of delivery of health care, in the methods of education and in bioscience will determine our future.

4. Medical students must come from broader social and economic backgrounds, and a larger part of their education must be intermixed with work within the culture from which the student originates.

5. The educational base of some physicians must include more of the social, informational and engineering sciences.

6. New institutional forms capable of marrying public and private monies for the support of the health field must be developed. National health insurance is a necessity, but it does not have to be a function of government alone. ◄

In 1967, Mr. Sam N. Regenstrief, of Connersville, created the Regenstrief Foundation for Research in Health Care.

Its operating arm, the Regenstrief Institute, was established at the Marion County General Hospital in Indianapolis in 1969, and directed to establish a broad research program on new and better ways to deliver health care. As part of its program, a series of lectures will be sponsored to bring to Indianapolis a number of leaders in various aspects of health care delivery.

The first of these Regenstrief Lectures was delivered by Dr. Eugene A. Stead, Jr., Professor of Medicine at Duke University School of Medicine. Dr. Stead is widely known as a medical educator and was the initiator of the Physician's Assistant program at the Duke Medical Cener.

Hoosier Teen Health Happening

OVER 3,000 Hoosier high school students representing 215 Indiana public, private and parochial schools attended the first annual "Hoosier Teen Health Happening" held in Indianapolis April 23 and 24 at the Indiana State Fairgrounds.

According to Dr. Lowell H. Steen, Hammond, president of the Indiana State Medical Association, the conference was successful far beyond anyone's anticipation.

"The day and a half conference, which dealt with drug use, alcoholism, mental health, traffic safety, and smoking, met with such enthusiasm by our youthful audience, the teachers, and the chaperones, that ISMA is already formulating plans for another similar program," Dr. Steen said.

"WFBM-TV, Channel 6, Indianapolis, televised the conference live in color. Reaction to the conference through the station's rating program was the highest that the station has ever received in programming of this nature," Dr. Steen further pointed out.

ISMA survey results of the program additionally have indicated high enthusiasm for the subjects and speakers. Format of the program was 30-minute presentations by each speaker, with an additional 30 minutes for questions and answers from the student audience.

"The frankness and intelligence of the questions by the young people added to the program's spirit and extraordinary attraction," Dr. Steen said. "The surge for truth about all of these subjects was indeed a revelation, which has left the officers of the ISMA and the officials of WFBM-TV absolutely amazed and elated," he added.

One student remarked that she appreciated being invited to the meeting since she learned more than she could have ever learned from her family or her school.

The program included such topics as "The Speed Scene"—use and abuse of the "speed" drugs; "How to Kick the Habit"— described by teenagers who did; "The Tappa Kegga Da Fraternity"—a discussion of teenage drinking; "Judgment Day Is Here—Now"—law enforcement and the teenager; and "Hawk, Dove or Chicken?"—highway safety and youthful drivers. Other topics were "Smoking and Other Burning Issues"—tobacco and its effects; "Why Students Crack Up"—an approach to student mental health; "Soul Is More Than Music"—the role of religion in mental health and "Sex and the Teen-Ager"—sex isn't a four-letter word.

Follow-up to the program will include providing taped recordings to the schools on loan, 16-millimeter films of each presentation, and additional presentations of the program through local and educational television outlets.

In a final commentary Dr. Steen said, "We felt that this program would be a good public relations effort by ISMA, and the results have substantiated the fact that it was, indeed, its finest P.R. accomplishment." ◄

HIGH SCHOOL representatives listen attentively to the "Teen Health Happening" speakers.



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After only one year:

Administered to more people than live in Hammond, Elkhart, and Lafayette.*



Injectable Garamycin®
brand of gentamicin sulfate injection

*An estimated 208,000 patients have received GARAMYCIN Injectable to date. The combined population of Hammond, Elkhart, and Lafayette is 198,000. (Estimated 1969 figures from The New York Times Encyclopedic Almanac 1970.)

See Clinical Considerations section on last page...

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ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe	Resistant/ Moderately Severe	Serious/Life-Threatening
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentrations of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

Adverse Reactions: The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of I gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

For more complete prescribing details, consult package insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07083.

AHFS CATEGORY 8:12.28 S-029



GLEANED FROM THE BRITISH MEDICAL JOURNAL

JACK W. HICKMAN, M.D.
Indianapolis

Ampicillin Does Not Enter Abnormal Bile Ducts

As with many therapeutic problems it is important to know the drug actions in disease states as well as in the normal individual. The present study by Mortimer et al.[1] reports on clinical investigation of this nature. Noting that Ampicillin is often used in the treatment of acute cholecystitis and ascending cholangitis, the authors measured the concentration of Ampicillin in the bile of patients with various types of biliary malfunction. They discovered that the drug was either absent or present in quite low concentration in patients who had non-visualizing gallbladders. They also found that patients suffering from obstructive jaundice did not have therapeutic levels of the drug in their bile. The authors conclude that Ampicillin is unlikely to be effective in biliary tract infection when obstruction is present. It is hard to quarrel with their conclusion.

TV Studies on Aspirin Confirmed

Most of us have read studies that demonstrated that aspirin placed directly on the intestinal mucosa will induce a small amount of blood oozing. Should we forget this, we are often reminded by television commercials of the irritating effects of aspirin on the G. I. tract. Few studies have been done to evaluate systematically given aspirin to cause G.I. bleeding, however. Cook and Goulston[2] have completed just such a study on 15 healthy male volunteers. They infused sodium acetylsalicylate intermittently over a period of days and measured fecal blood loss. These authors were unable to demonstrate any fecal blood loss and their conclusion is, therefore, that the mucosal blood loss from unbuffered acetylsalicylic acid is due to the local action of the drug on the gastric mucosa.

Caution Advised With Nephrotoxic Analgesics

Since the British were among the first to draw our attention to analgesic nephropathy, we should listen when they continue to tell us about it. Bell et al.[3] have followed 11 of these patients for nine to 88 (mean 36) months after withdrawal of the offending agent. They report that 10 of the 11 are alive and either improving, stable or have manifested no more than slowly declining renal function. Even though early diagnosis is extremely important in this condition, as it is in almost everything else in medicine, it is heartening to see that unrelenting rapid deterioration need not be the course. The authors stress that analgesic withdrawal is still beneficial, even in cases that have advanced renal failure at the time of diagnosis. Unfortunately too many of us probably need to be reminded frequently to think of this condition, but it is indeed real, and warrants our consideration.

REFERENCES

1. Mortimer, P. R., Mackie, D. B., Haynes, S.: Ampicillin Levels in Human Bile in the Presence of Biliary Tract Disease, *Brit. Med. J.* 3:88-89, No. 5662.
2. Cooke, A. R., Goulston, K.: Failure of Intravenous Aspirin to Increase Gastrointestinal Blood Loss, *Brit. Med. J.* 3:330-332, No. 5666.
3. Bell, D., Kerr, D. N., Swinney, J., Yeates, W. K.: Analgesic Nephropathy. Clinical Course after Withdrawal of Phenacetin, *Brit. Med. J.* 3:378-382, No. 5667. ◄

Tell City Physicians Offer 24-Hour Service

IN a quiet little southern Indiana town changes are being made in the delivery of health care to its citizens locally and to the surrounding communities.

And, quietly, without fanfare, the changes are being wrought by five physicians who may be setting the pace and precedent for a system which could reverberate throughout Indiana and the nation.

On Memorial Day, 1969, the Tell City Clinic became operational as a new, beautifully designed and equipped building on Route 66 to guarantee 24-hour, seven-day-a-week service to the sick and injured.

The five general practitioners involved are Drs. Lewis C. Lohoff, Noel L. Neifert, Gene E. Ress, Fred Smith, Jr., and Robert A. Ward. Average age of the group is 41.

Prior to moving into the new clinic, the five physicians were established in a leased building in midtown Tell City. The building and space became progressively inadequate in spite of several remodelings.

"With the deaths of three of our colleagues in Tell City we were not only faced with a shortage of space to care for patients," Dr. Smith said, "but we were additionally faced with the industrial growth on both the Indiana and Kentucky sides of the Ohio River which are, of course, attracting increasing numbers to the area, all of whom need medical care and hospitalization."

Round-the-Clock Service

To meet the increased demand for medical care these family practitioners formulated a schedule which makes 24-hour service available from the clinic.

"We take turns at overnight and week-end duty," Dr. Smith said.

Situated within the spaciousness of the new clinic is a modern, comfortable room equipped with television, radio, shower, a library and bed and all of the comforts of home for the doctor on duty as he spends his time away from family and friends.

On duty with the physician is a senior student from the high school who has been trained by the physicians as an overnight assistant. These young men are usually biology or other science majors.

The clinic physicians feel that they are not only effective help but have an excellent opportunity to consider medicine as a career.

Commenting upon the action taken by the physicians in Tell City, all of whom are members of the Indiana State Medical Association, Dr. Lowell H. Steen, Hammond, president of the ISMA said, "This is an excellent example of physicians working together to meet the needs of patients in the community in a voluntary way.

"The same pattern of operation might not be applicable to every community or all physicians, but it does meet the specific problem in that community," he said.

Ambulance drivers bring patients directly to the clinic at night for treatment unless, in their judgment, the case warrants delivering them to the county hospital emergency room just a few blocks away from the clinic.

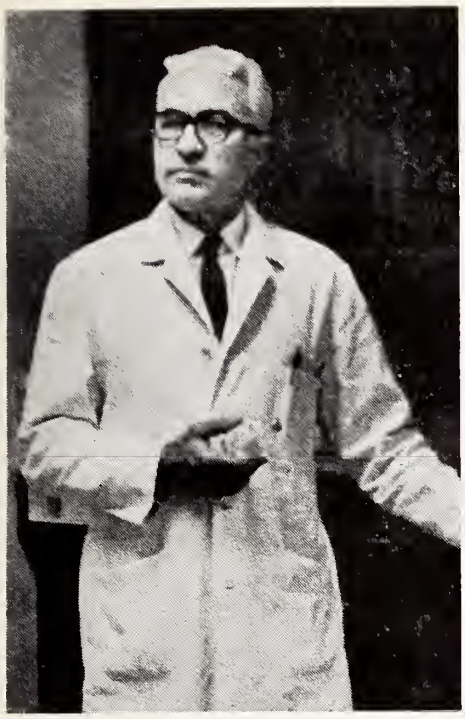
When delivery to the hospital occurs, the patient's family physician is called to meet the patient at the hospital emergency room where more extensive surgery may be needed. In other cases the clinic physician on duty proceeds to handle the case at the hospital.

The clinic operates as the main emergency site, however, where the great majority of situations can be managed.

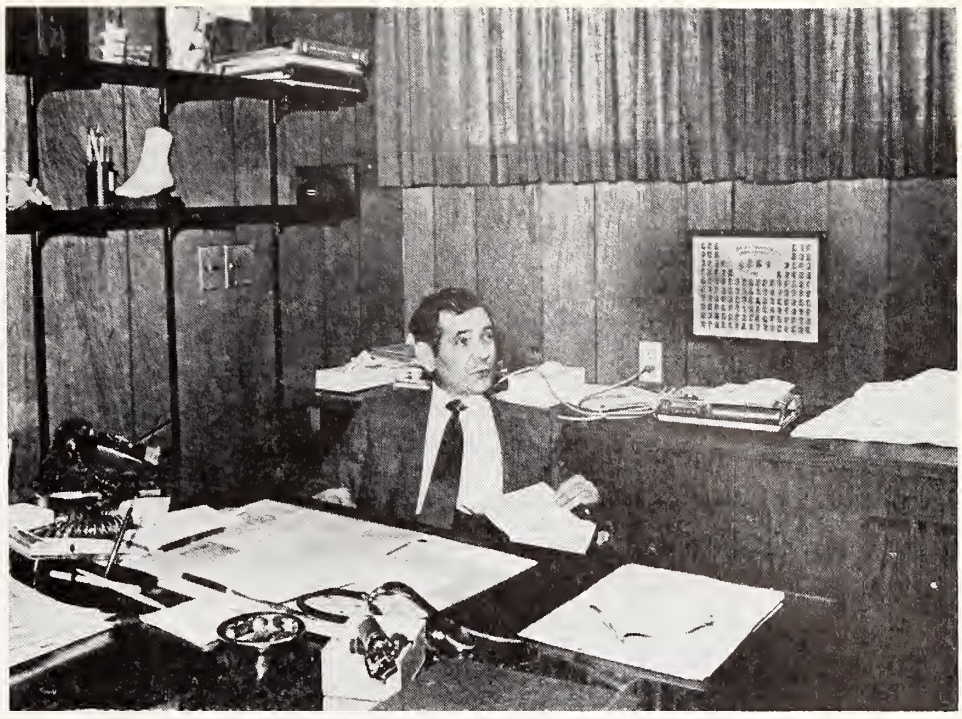
The clinic has a well-equipped emergency room. At times, the injured are held for observation, especially where head injuries are involved, with the final decision on



LABORATORY and x-ray technician Donna Hammack, Tell City, examines an x-ray with Dr. Robert A. Ward, who joined the group in September, 1969, after serving as a medical officer in Viet Nam.



DR. NOEL L. NEIFERT checks medications in one of the clinic's surgeries.



OFFICE of Dr. Fred Smith, Jr., is typical of the other physicians' offices in the new structure.

taking the patient to the hospital left to the duty doctor's discretion.

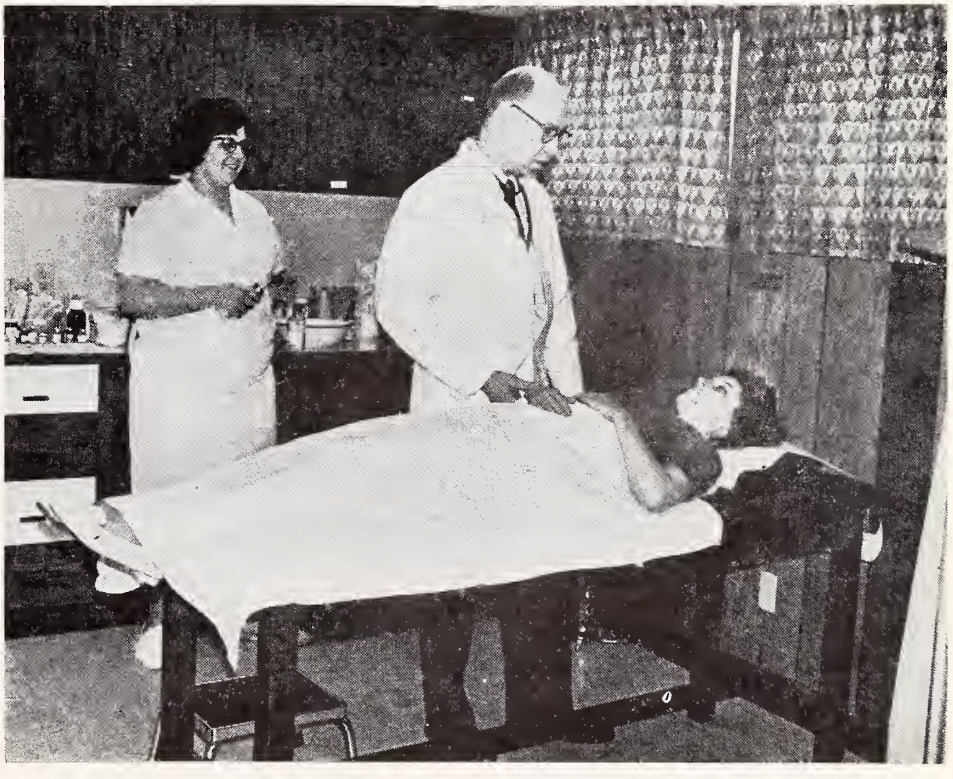
30% More Efficiency

Emphasis in the 24-hour service is not on emergencies only, however. Individuals may bring in a sick child or anyone feeling the need of medical attention at any time. The physicians at the clinic urge their patients to make their visits during regular office hours and the availability of the night-time service has not been abused.

The doctors estimate that they are operating at 30% more efficiency and pointed out that even with the increased load of patients, their personal lives have become more normal.

The physician who is to be on duty any given night leaves the clinic at 5:00 p.m. to acquaint himself with all of the group's hospital cases. He returns at 7:00 p.m. to take over with his student assistant and stays on until 7:00 a.m. Saturday and Sunday schedules are planned so that doctors are on duty continuously. Scheduling has worked out to the satisfaction of everyone.

The clinic offers a complete labora-



DR. GENE E. RESS checks patient Mrs. Lewis Heitkemper, Tell City, in the emergency examination room of the Tell City Clinic. Nursing Assistant Ruth Ann Cunningham is in the background.

tory service as well as x-ray service. In their 30,000 square feet of space, 15,000 square feet contain 27 examining rooms and 10 consultation rooms.

The physicians employ three registered nurses, one licensed practical nurse, two nursing assistants and six in the administrative section, two of whom process private and governmental insurance claim forms.

A local pharmacist has leased space in the building, which is immediately available to patients. In tune with the contemporary design of the new facility, the doctors keep current on the latest care and treatment. Written into their agreement of partnership is the stipulation that each will take two weeks of postgraduate medical education courses during the year.

"We've got plenty of room for expansion," a member of the group said, "to serve this community of 7,700 and an estimated 35-mile area around Tell City. As this community grows, we intend to keep pace. We have enough space for a total of 14 physicians, and we feel no one can say they can't get prompt necessary medical care at any time of the day or night." ◄



DR. LOUIS C. LOHOFF (left) and Dr. Fred Smith, Jr., leave the new clinic building on their way to the hospital to check patients.

New Highway Safety Literature Available

The Insurance Institute for Highway Safety has published a new, free catalog listing the sources of highway safety literature published by 44 organizations. Most of the pamphlets listed are prepared for lay readership—the driver, pedestrian, bicyclist, safety education student and civic officials—but physicians will find that considerable technical literature is also available.

For a copy, write to the Insurance Institute for Highway Safety, 711 Watergate Office Bldg., 2600 Virginia Ave., N.W., Washington, D.C. 20037.



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Opening your own practice can be extremely difficult and costly... but a helping hand from White-Haines will make it much easier.

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Blue Shield Office Staff Services Physician Inquiries

(One of a series)

Last month your Blue Shield Professional Relations field staff was discussed. Less seen, and less known, but no less important, is an internal office staff, whose sole purpose is prompt and accurate service to physicians and their assistants.

Under Herbert P. Dixon, vice president, Professional Relations, office manager Thomas E. Erwin and supervisor David Widdifield operate a staff of eight physician inquiry consultants. The relatively new unit within Professional Relations was initiated to improve services to the state's physicians.

"We consider the physician inquiry consultant one of the most responsible positions within Blue Shield," Dixon said. "Knowledge, tact, a business-like manner, and a pleasant voice are all required, and we're all proud of the job these girls are doing for the physicians."

Every one of the consultants has some college training, with three having B. S. degrees.

Five of the consultants handle telephone inquiries received on the "open lines."

Donna Biehl, a graduate of Kennedy Memorial High School in Indianapolis, attends Indiana University part time, and has a journalism background. She was a youth reporter for *The Star* and *News* in Indianapolis and worked on the I.U. yearbook staff.

Julieanne Donovan has earned a B. S. degree in social work from Indiana State University and is a member of Alpha Phi Sorority. Married, she enjoys swimming, cooking and sewing.

Janet Huard is a transplanted Buckeye from Pioneer, Ohio, with a sociology degree from Bowling Green State University. She and her serviceman husband enjoy travel. Janet is a member of Delta Zeta sorority.



BEHIND the service are people. Assisting physicians with information via phone and mail are these physician inquiry consultants. Seated is Grace Wollersheim; standing from left, Elaine Glanzman, Lisa Norman, Claudia Bohard, Donna Biehl, Julieanne Donovan, Marlea Jo Jordan, and Janet Huard.

Marlea Jo Jordan also comes from Ohio, and has a degree in education from Ohio State University, where she was a Delta Sigma Theta. She is married and enjoys several sports, sewing and reading.

Grace Wollersheim comes to Indiana from Wisconsin, and is a native of Two Rivers. She attended the University of Wisconsin and likes music, reading and knitting.

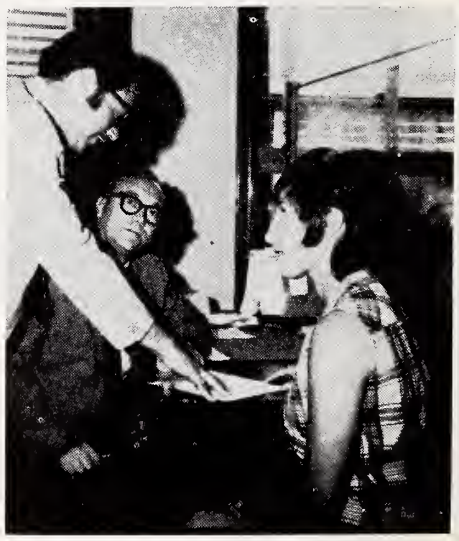
Two consultants specialize in answering correspondence from physicians.

Claudia Bohard is a graduate of North Central High School in Indianapolis, and attended Indiana University. She likes theater, music and psychology.

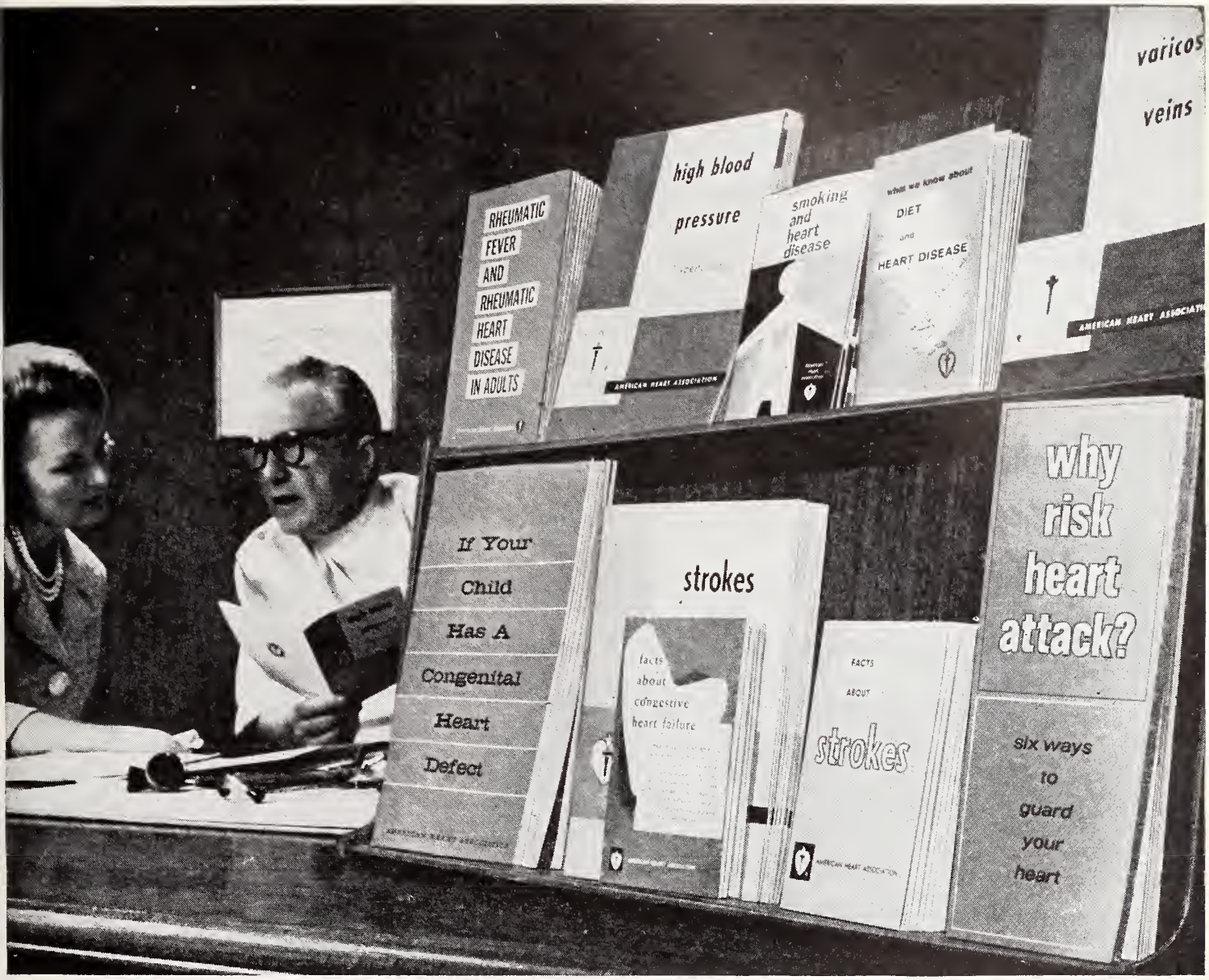
The newest consultant, Lisa Norman, was graduated from Lawrence Central High School and attended Indiana University. Married and the mother of one girl, she enjoys sewing and cooking.

Supporting the efforts of all the rest is Elaine Glanzman, who researches the information often needed for correspondence or return calls. She was graduated from Broad Ripple High School and attended Ball State University. Elaine is married, and enjoys coin collecting in her spare time.

Stanley A. Huseland
Public Relations



TACKLING the problems is the responsibility of David Widdifield, office supervisor; Thomas E. Erwin, office manager; and consultant Elaine Glanzman, who researches claim information to back up the other consultants.



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Ask your local Heart Association for a catalogue listing all these free materials and order a supply.

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NEWS FROM THE I.U. SCHOOL OF MEDICINE

One of Indiana's outstanding medical educators, Dr. Walter J. Daly, has been appointed to succeed the late Dr. John B. Hickam as chairman of the department of medicine of the Indiana University School of Medicine.

Dr. Daly, now professor of medicine, has been a member of the medical school faculty since 1962.

As chairman of one of the school's largest and most important departments, Dr. Daly will have several major responsibilities:

1. The continuing implementation of a new school of medicine curriculum which is nationally regarded as one of the most innovative reforms now under way in American medical education;

2. The continuing development of the new education and patient care affiliation between the school of medicine and Marion County General Hospital;

3. The continuing growth of medicine education programs for medical students, interns and resident physicians, and practicing physicians on a statewide scale.

"The chairman of medicine at this school has unusually heavy responsibilities which had grown under the leadership of Dr. Hickam," said Dr. Glenn W. Irwin Jr., dean of the I.U. School of Medicine.

"We have chosen an excellent physician and educator in Dr. Daly for the very difficult task of maintaining the growth of the department of medicine," he said.

Dr. Daly, a native of Michigan City, was graduated from Muncie Burris High School. As an undergraduate student at Indiana University at Bloomington, he was elected to Phi Beta Kappa, the national scholastic honorary society. Dr. Daly was graduated from the I.U. School of Medicine in 1955. He took his internship and residency training in the Indiana University hospitals.

After service in the United States Army Medical Corps, during which he served as chief of the medical service at the Fort Lawton, Wash., Army Hospital, Dr. Daly returned to the school of medicine to continue his studies under a United States Public Health Service Fellowship.

He has served as associate editor and acting editor of *Clinical Research* and is presently a member of the editorial boards of the *Journal of Applied Physiology* and the *American Journal of Physiology*.

Dr. Daly has published numerous articles in scientific and medical journals reporting research in lung and circulatory system diseases. He is director of the Indiana University Cardiovascular Research Center. ◄

Sandoz announces...

a new agent for the alcohol-dependent patient who wants to quit

and

a program for the Indiana physician who wants to help





a major tranquilizer with specific advantages for the alcohol-dependent patient:

1. Alleviates tension, anxiety, and depression; may also ease prevalent neurotic symptoms in personality disorders.
2. No reported habituation or addiction.
3. Antiemetic properties to control nausea and vomiting.
4. Has not caused hepatic dysfunction or interfered with functional recovery of impaired liver.
5. Four tablet strengths to allow flexibility of dosage (usual starting dose: for the problem drinker, 10 mg. t.i.d.; for the frank alcoholic, 25 mg. b.i.d.).
6. Injectable form available for acute episodes.



a program for early recognition and successful treatment:

Alcoholism in Indiana*

State Rank

total no. alcoholics	13th
no. per capita	20th
per capita consumption†	37th

Indiana Physicians' Report
(compared with U.S. average)

	%Ind.	%U.S.
see 5 or more problem drinkers in 2-month period	38.4	37.1
half or more seen are women	38.8	37.4
treat, rather than refer	73.2	72.6
more community services needed	61.7	63.0

*based on preliminary data supplied by Center of Alcohol Studies, Rutgers Univ. †absolute alcohol

The Ins-and-Outs of Alcoholism: A series of recordings and other mailings, each concerned with a particular aspect of the alcohol problem. Recognized authorities in the field discuss the scope, recognition and treatment of alcohol-dependent patients. Also included will be **The Alcoholic Directory,** a nationwide survey of treatment centers.

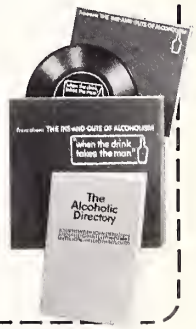
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See next page for prescribing information.

SERENTIL®
(mesoridazine)
new weapon in the fight against alcoholism

INDICATIONS: In clinical studies, Serentil (mesoridazine) has been found useful in the following disease states:

Alcohalism—*Acute and Chronic:* Serentil ameliorates anxiety, tension, depression, nausea and vomiting in both ocute and chronic alcoholics without producing hepatic dysfunction or hindering the functianal recavery of the impaired liver.

Schizaphrenia: Serentil is effective in the treatmenr of schizaphrenio. It substantially reduces the severity of Emotional Withdrawal, Conceptual Disorganization, Anxiety, Tension, Hallucinatory Behavior, Suspiciousness and Blunted Affect in schizophrenic patients. As with other phenathiazines, patients refractary to previous medication may respond to Serentil.

Behaviaral Prablems in Mental Deficiency and Chranic Brain Syndrame: The effect of Serentil was found to be excellent or good in the management of hyperoctivity ond uncooperativeness associated with Mental Deficiency and Chronic Brain Syndrome.

Psychaneuratic Manifestatians: Serentil reduces the symptams of anxiety and tension, prevalent symptoms often associoted with neurotic camponents of many disorders, and benefits personolity disorders in general.

CONTRAINDICATIONS: As with other phenothiazines Serentil (mesoridazine) is contraindicated in severe central nervous system depression or comotose states from any cause. Serentil is contraindicated in individuals who have previously shown hypersensitivity to the drug.

WARNINGS: Where patients are participating in activities requiring complete mental alertness (e.g., driving), it is advisable to administer the phenothiazines cautiously ond to increase the dosoge gradually.

Usage in pregnancy: The sofety of this drug in pregnancy has not been established; hence, it should be given only when the anticipoted benefits to be derived from treotment exceed the possible risks to mother and fetus.

Usage in children: The use of Serentil in children under 12 yeors of age is not recommended, because sofe conditions for its use hove not been estoblished.

Attention should be paid to the foct that phenothiazines are copoble of potentioting centrol nervous system depressonts (e.g., anesthetics, opiates, alcohol, etc.) as well os otropine and phosphorus insecticides.

PRECAUTIONS: While oculor chonges have not to date been related to Serentil, one should be oware that such chonges hove been seen with other drugs of this closs.

Becouse of possible hypotensive effects, reserve parenteral odministration for bedfost potients or for acute ambulotary cases, ond keep patient lying down for at least ½ hour after injection.

Leukapenia ond/or ogronulocytosis hove been attributed to phenothiozine theropy. A single case of tronsient granulocytopenio hos been ossocioted with Serentil (mesoridozine).

ADVERSE REACTIONS: Drowsiness and hypotension were the most prevolent side effects encountered. Side effects tended to reoch their maximum level of severity early with the exception of o few (rigidity and motoric effects) which occurred later in therapy.

With the exceptions of tremor and rigidity, odverse reoctions were generally found omong those patients who received relatively high doses early in treotment. Clinical data showed no tendency for the investigotors to terminate treatment because of side effects.

Serentil has demanstrated a remarkably low incidence of adverse reactions when compared with other phenothiazine compounds.

Central Nervaus System: Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, atoxio, dystonio, rigidity, slurring, okathisia, motoric reactions (opisthotonos) have been reported.

Autanamic Nervaus System: Dry mouth, nousea and vomiting, fainting, stuffy nase, photophobio, constipation and blurred vision have occurred in some instances.

Endacrine System: Inhibition of ejaculotion and lactotion hove been noted rarely.

Skin: Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema have been reported.

Cardiavascular System: Hypotension and tachycordio have been reported. EKG changes hove occurred in some instances (see Phenothiazine Derivatives: Cardiovascular Effects).

Phenothiazine Derivatives: It should be noted that efficacy, indications and untoward effects have varied with the different phenothiazines. The physicion should be owore that the following hove occurred with one or more phenothiazines ond should be considered whenever one of these drugs is used:

Autanamic Reactians: Miosis, obstipotion, anorexia, porolytic ileus.

Cutaneous Reactians: Erythemo, exfoliative dermatitis, contact dermotitis.

Blaod Dyscrasias: Agranulocytosis, leukopenio, eosinophilia, thrombocytopenia, anemio, aplastic anemio, poncytopenia.

Allergic Reactions: Fever, laryngeal edema, angioneurotic edemo, osthmo.

Hepatataxicity: Jaundice, biliory stasis.

Cardiavascular Effects: Chonges in the terminal portion of the electrocardiogrom, including prolongation of the Q-T interval, lowering and inversion of the T-wave ond oppeoronce of o wove tentotively identified as o bifid T or a U wove hove been observed in some potients receiving the phenothiozine tronquilizers, including Serentil (mesoridazine). To dote, these oppear to be due to oltered repolarization and not related to myocordial damoge. They oppeor to be reversible. There is no evidence at present thot these chonges are in any woy precursors of ony significont disturbance of cordiac rhythm.

Hypotension, rarely resulting in cardioc arrest, has been noted.

Extrapyramidal Symptams: Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonos, oculogyric crises, tremor, muscular rigidity, akinesio—some of which an rore occasions hove persisted for several months or years especially in patients of advonced oge with brain damage.

Endacrine Disturbances: Menstruol irregulorities, altered libido, gynecomostia, weight gain. False positive pregnancy tests have been reported.

Urinary Disturbances: Retention, incontinence.

Others: Hyperpyrexia. Behoviorol effects suggestive of a parodoxical reaction have been reported. These include excitement, bizarre dreoms, aggravation of psychoses ond toxic confusional states. More recently, a peculiar skin-eye syndrome has been recognized as a side effect following long-term treatment with phenothiozines. This reoction is marked by progressive pigmentatian of areas of the skin or conjunctiva and/or accompanied by discoloration of the exposed sclero ond cornea. Opocities of the anterior lens ond cornea described as irregulor or stellate in shape have also been reported.

DOSAGE AND ADMINISTRATION: Oral: The dasoge of Serentil (mesoridazine), as in most medicotions, should be adjusted to the needs of the individual. The lawest effective dosage should always be used. When maximum response is ochieved, dosage may be reduced gradually to a maintenance level.

Alcahalism: For most patients the usual starting dose is 25 mg. b.i.d. The usuol optimum total doily dose ronge is 50-200 mg. per day.

Schizaphrenia: For most patients, regardless of severity, a starting dose of 50 mg. t.i.d. is recommended. The usual optimum total doily dose range is 100-400 mg. per doy.

Behavioral Prablems in Mental Deficiency and Chranic Brain Syndrame: For most patients a storting dose of 25 mg. t.i.d. is recommended. The usuol optimum total daily dase range is 75-300 mg. per day.

Psychoneurotic Manifestations: For most patients the usual starting dase is 10 mg. t.i.d. The usuol optimum totol doily dose range is 30-150 mg. per day.

Injectable Form: In those situations in which an intromuscular form of medication is indicated, Serentil (mesoridozine) Injectable is ovailable. For most patients a storting dose of 25 mg. is recommended. The dose may be repeated in 30 to 60 minutes, if necessary. The usual optimum total daily dose range is 25-200 mg. per day.

HOW SUPPLIED: Tablets: 10 mg., 25 mg., 50 mg., ond 100 mg. mesoridozine (as the besylote). Bottles of 100.

Ampuls: 1 cc. [25 mg. mesoridozine (os the besylote)]. Inoctive ingredients—Disodium Edetote, U.S.P., 0.5 mg.; Sodium Chloride, U.S.P., 7.2 mg.; Carbon Dioxide Gos (Bone Dry), q.s.; Water for Injection, U.S.P., q.s. to 1 cc. Boxes of 20 ond 100.

SER70-101

Sandoz Pharmaceuticals, Hanover, N.J.

Report on Actions of the House of Delegates

American Medical Association
119th Annual Convention
June 21-25, 1970
Chicago, Ill.

K. W. BUSH
Administrative Assistant, ISMA

INDIANA'S full contingent of delegates and alternate delegates attended the 119th annual convention of the American Medical Association, June 21 through 25 in Chicago.

Accompanying the delegation were Drs. Lowell H. Steen, Hammond, president; Malcolm O. Scamahorn, Pittsboro, president-elect and Peter R. Petrich, Attica, chairman of the Board.

The delegation chaired by Dr. Eugene F. Senseny, Fort Wayne, reviewed all of the advance material distributed prior to the meeting and met every morning during the five-day session at breakfast to consider late resolutions introduced to the AMA House, as well as plan voting strategy on many of the major issues. The delegation also met at noon each day to continue deliberations.

All four AMA presidential candidates met with the Indiana delegation prior to the Thursday morning elections as well as candidates for other offices of the AMA including the Board of Trustees. Under the circumstances the Indiana group had an excellent opportunity to hear each candidate's personal platform.

A former president of the Indiana State Medical Association, Dr. Guy A. Owsley, Hartford City, was elected chairman of the important AMA Council on Medical Service during the session.

Indiana's delegation included Drs. Don E. Wood, Indianapolis; Frank H. Green, Rushville; Jack E. Shields, Brownstown; John S. Farquhar, Fort Wayne, and Eugene F. Senseny, Fort Wayne.

Alternate delegates included Drs. James A. Harshman, Kokomo; Eugene S. Rifner, Van Buren; Kenneth O. Neumann, Lafayette; Patrick J. V. Corcoran, Evansville; and Thomas C. Tyrrell, Hammond.

Also on hand to meet with the delegation throughout the week were Drs. Sprague H. Gardiner, Indianapolis delegate from the AMA Section on Obstetrics and Gynecology; Lall H. Montgomery, Muncie, delegate from the AMA Section on Pathology and Physiology and Myron H. Nourse, Indianapolis, alternate delegate from the AMA Section on Urology.

Indiana's delegation introduced two resolutions to the House of Delegates: one asked for a more aggressive AMA attitude in its communications and public relations programs while the other asked that the Himler Report be referred to a new Committee on Planning and Development for continuous evaluation as a part of long-range planning for the AMA.

The communications resolution was referred to the Board of Trustees of the AMA.

Concerning the Himler Report and long-range planning and development, the Indiana resolution asked that the committee be a committee of the House, constituted of nine members of the House and one AMA trustee.

Indiana's resolution and others on the same subject caused one of the longest debates of the House with the final recommendation including a nine-member council made up of four appointed by the speaker of the House (two from the House and two from the membership at large); four appointed by the AMA Board of Trustees, (two members of the Board and two members from the membership at large). The ninth member is to be appointed by the president of the Student American Medical Association.

Some of the other Indiana officers in attendance at the meeting were Drs. Burton E. Kintner, Elkhart, member of ISMA Executive Committee; Lester B. Hoyt, treasurer, and Hugh K. Thatcher, assistant treasurer of the association, both of Indianapolis; Lowell H. Hillis, Logansport, ISMA trustee; Dwight W. Schuster, Indianapolis, ISMA trustee; Frederic L. Schoen, Fort Wayne, alternate trustee and G. Beach Gattman, Elkhart, alternate trustee.

In its first uninterrupted Annual Convention since 1967 (thanks to the most elaborate security precautions ever taken), the House of Delegates considered a record volume of business; passed a hotly debated statement on abortion; raised membership dues to help finance needed programs; heard outgoing president Gerald D. Dorman challenge the association to attain and maintain a specific minimum health standard of "a healthy child and a healthy mother;" and applauded newly inaugurated president Walter C. Bornemeier's call for greater emphasis on patient care through an overhaul of medical education and training.

Elections

Wesley W. Hall, Nevada, was elected president elect, defeating two other trustees and one delegate running for the position. Dr. Hall

will become the 126th president of the AMA in June, 1971.

H. Thomas McGuire, Delaware, was elected vice president and Russell B. Roth, Pennsylvania, and J. Frank Walker, Georgia, were unanimously re-elected to their posts as speaker and vice speaker of the House, respectively.

John H. Budd, Ohio; Richard E. Palmer, Virginia; James H. Sammons, Texas; and Kenneth C. Sawyer, Colorado, were elected to fill the four vacancies on the Board of Trustees.

George W. Petznick, Ohio, was re-elected to the Judicial Council.

M. Louise C. Gloeckner, Pennsylvania, was elected to the Council on Constitution and Bylaws.

Warren L. Bostick, California, and Bernard J. Pisani, New York, were elected; and Bland W. Cannon, Tennessee, was re-elected to the Council on Medical Education.

Paul W. Burleson, Alabama, was elected; and Donald R. Hayes, Massachusetts, and W.B. Hildebrand, Wisconsin, were re-elected to the Council on Medical Service.

Final Report and Inaugural Address

In his final report to the House, Gerald D. Dorman reminded the profession that "We expect to be recognized and accepted as the leaders of medical and health care planning and action. . . because our experience has made us the best qualified to give leadership in medical care. But if we are to continue in that position, we must earn it. We must deserve it, not because of reputation or tradition, but because of visible achievement. . . ."

After repeating his hope (first stated in Denver) that the 1970's would be the Significant Seventies in medical and health care, Dr. Dorman said, "I should like to set a specific minimum health standard for the American Medical Association to attain and maintain. That is a healthy child and a healthy mother. This does not require a resolution of this House; it does not require legislation or funding. It only requires personal dedication and commitment.

"Already this is being carried out in many places that I know of, and surely in many that I do not. Already the infant and maternal death rates are falling, but I speak also of infant and maternal morbidity. There are lives of mothers and of children permanently damaged for lack of proper care. This is not necessarily a fault of organized medicine because poverty, ignorance, malnutrition and bad sanitation take their toll. These we, as crusading citizens, must overcome now, as leaders in our drive for a healthy child and a healthy mother. . . .

"I want to see all our physicians —our obstetricians and gynecologists, our pediatricians, our general practitioners, our internists and other specialists—renew their contact with the rest of the health team and rededicate themselves to this minimum health standard. . . throughout our population."

Walter C. Bornemeier, in his inaugural address as the AMA's 125th president, cited five areas for improvement in medical education and training: shortening the medical school curriculum; modernizing and shortening residency programs; relating more medical training to patient care at an earlier point; assimilating full-time teachers into patient care; and reducing the number of medical research institutions and researchers.

"In any new graduate program, we might be advised to emphasize again a preceptorship method of training," he said. "If M.D. graduates could be trained in the active practice of medicine outside the hospital with a physician or group approved for teaching, the doctor shortage would in large measure be solved." He pointed out that such training would emphasize what makes people sick as well as how to make them well again.

Those changes would allow the physician to undertake more rapidly the responsibility "commensurate with his skills and knowledge" and might "overnight add 50,000 doctors to the care of patients in our communities."

Dr. Bornemeier praised medical schools for moving in the right direction. He advocated a goal of six years from high school to the M.D. degree and added that in some schools, first-year students can go directly into a patient-oriented curriculum because "the conventional freshman year in medicine is being given as the final year" of pre-med schooling.

The president said there are now some 35,000 M.D.s in residencies who, 25 years ago, would already have been in active practice. Another 5,000 physicians have quit practice to assume positions as medical educators in hospital residency training programs. And another 10,000 to 12,000 M.D.s are full-time educators in medical schools, a function that 25 years ago "was done by those of us in practice."

The House heard other brief speeches from the president of the National Medical Association; the chairman of the AMPAC Board; and the president of SAMA.

House Actions

From June 21 through June 25, the House was in business sessions for 17 hours and 15 minutes, during which it considered a record 201 items of business. Included were 61 reports — 31 from the Board; three from the Judicial Council; six from the Council on Constitution and Bylaws; 10 from the Council on Medical Education; five from the Council on Medical Service; and six special reports. It also dealt with 140 resolutions — eight un-numbered memorial or commendatory ones; 27 special ones generated by the (Himler) Committee on Planning and De-

velopment; and 105 from regular sources.

Abortion: After long debate before the reference committee and on the floor of the House, delegates adopted the following statement on abortion:

"Whereas, abortion, like any other medical procedure, should not be performed when contrary to the best interests of the patient since good medical practice requires due consideration for the patient's welfare and not mere acquiescence to the patient's demands; and

"Whereas, the standards of sound clinical judgment, which, together with informed patient consent should be determinative according to the merits of each individual case; therefore be it

"Resolved, that abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in an accredited hospital acting only in conformance with standards of good medical practice, and after consultation with two other physicians chosen because of their professional competence, and within the Medical Practice Act of his state; and be it further

"Resolved, that no physician or other professional personnel shall be compelled to perform any act which violates his good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional personnel withdraw from the case so long as the withdrawal is consistent with good medical practice."

Consumer Forum: For the first time in its history, the House appointed a special reference committee to hold a public forum, at which individuals and representatives of groups could present their views of medical and health care. The committee heard three hours of testimony on the opening day of the convention. From its report, the House adopted the following recommendations:

"That consideration be given by the Board of Trustees to the creation of a multi-ethnic advisory committee on health care problems of minority groups.

"That the House of Delegates reaffirm its policy of encouraging physicians, as well as paramedical personnel, to continue to provide compassionate and sympathetic care to all patients.

"That the House of Delegates reaffirm Resolution 62, Annual Convention 1969, which states in part: 'It is a basic right of every citizen to have available to him adequate health care' . . . and that 'the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person.'

"That the AMA Advisory Committee on Health Care of the American People be invited to participate in reference committee hearings" of this type if they are held in the future. Consideration of having such an open forum at each AMA convention was referred to the Board of Trustees.

Dues Increase: Until this convention, the amount of AMA dues was prescribed by the Board, for adoption or rejection by the House. On Tuesday, however, the House amended the bylaws to give itself that responsibility. Chapter III, Section 1 (A) of the bylaws now reads:

"(A) How Prescribed - Annual dues for any year shall be prescribed in an amount fixed and determined by the House of Delegates. The Board of Trustees may submit recommendations to the House on the fiscal needs of the association and the level of dues. Dues fixed by the House shall remain in effect until changed."

In response to Board Reports A and B (financial statement of the AMA, and background detail on the need for an increase), the House voted to increase annual AMA dues by $40, to $110. At the same time, the House directed that "basic and explicit information supporting the need for this dues increase, and future dues increases, be promptly disseminated by the AMA to individual members by every reasonable and available means possible; and that the aid of constituent state associations be enlisted in this effort."

The new dues will become effective with the next fiscal year, beginning December 1, 1970.

Recommendations

That the AMA reaffirm, as a statement of the primary purpose and responsibility of the association and the medical profession, "the promotion of the art and science of medicine and the betterment of public health," and, as part of this purpose, apply all possible effort to make medical service of high quality available to all individuals.

That the association has the duty to guide and assist the medical profession in the attainment of this objective.

That the American Medical Association recognize the need for multiple methods of delivering medical services, and that it encourage and participate in efforts to develop them.

That, in the interest of attracting the most highly-qualified candidates to the field of medicine, it simultaneously make every effort to maintain and create incentives in medical practice. Among these incentives are a multiplicity of practice options, maximum professional independence and freedom of choice for both physicians and patients.

Health is a state of physical and mental well-being.

That the AMA expand its active role in planning and developing programs for medical care in all of its

ramifications and that it encourage and assist state and county medical societies to do the same at their respective levels.

That, clearly recognizing the health of individuals has many aspects other than medical care, such as education, housing, environmental control, transportation, civil rights, and the alleviation of poverty, the American Medical Association continue to show an active, innovative and constructive interest in these non-medical components of health services.

That the AMA and the constituent and component medical societies seek the active cooperation of all physicians, both as individuals and as members of medical staffs, in medical service projects for areas in need of medical services.

That the AMA, through its Council on Health Manpower, in conjunction with county and state medical societies and other professional, education, and lay associations, continue to explore and develop expedients to overcome health manpower shortages.

That the association, in its future declarations and activities directed toward the alleviation of shortages in health services and personnel, underscore the fact that these shortages are not due merely to an insufficient number of health professionals across-the-board, and emphasize that maldistribution of practitioners geographically, by profession, and by specialty is an equally important factor in depriving communities of an adequate supply and spectrum of health services.

That the association publicize the reasons for the maldistribution, as outlined in this section, and stress that the voluntary correction of these deficiencies requires public cooperation and community action in addition to the measures taken by the health professions.

That an appropriate committee of the AMA immediately begin to formulate a policy on physicians' assistants, particularly with regard to their responsibilities, limitations on their services, and supervision of their services by qualified physicians.

That the AMA reaffirm the principle that the basic responsibility for the medical care of patients lies with their physicians of record and that that responsibility cannot be legally or morally delegated.

That the AMA approve in principle certification of educational programs for physicians' assistants but oppose licensing of these individuals by any state agency.

That the association's Law Division upon request assist the state medical societies in identifying and avoiding any legal hazards that may accompany the employment of physicians' assistants.

In seeking as its goal the highest quality and availability of patient care, the American Medical Association advocates factual investigation and objective experimentation in new methods of delivery of health care, while still maintaining faith and trust in the private practice of medicine and pride in its accomplishments.

That the association, in appropriate public statements, emphasize the concept that differences in education, state laws, culture and income levels create problems that may necessitate different systems of delivering medical care for different population groups and different geographic areas.

Urge state medical associations to establish bureaus or departments of economic research, development and planning to study, develop and disseminate data concerning the economic aspects of medical practice.

Through the AMA's Departments of Survey Research and Economic Research, continue to assist state associations in collecting such data and to act as a clearinghouse for data so gathered.

Encourage state medical associations to designate representatives to deal energetically with third party agencies and programs, utilizing the concept of usual, customary or reasonable charges.

That the AMA reiterate its support of sound, existing mechanisms, such as public grievance and adjudication committees, and utilization and peer review committees, which state and county medical societies have found to be most appropriate and effective for the consideration of fees and the costs of medical and related care.

Endorse the principle of voluntary, lifelong postgraduate study for all physicians and continue and accelerate the development of programs and incentives for such study.

That the AMA encourage and assist all state medical associations to devise programs for voluntary postgraduate study designed to maintain medical education at the optimum level with the primary objective of assisting the physician in rendering professional services to his patients. These programs of postgraduate study should be mindful of the many demands on the time of the busy physician, and his responsibilities to his patients and his practice, and should be least disruptive to the provision of medical services.

That the association obtain information from each state medical society as to whether special requirements have been imposed on physicians who render services to patients under the provisions of tax-supported programs and obtain the specifics of what those requirements are.

That in those states where the health or welfare departments have imposed special requirements on physicians to participate in their programs, the medical society reject those requirements and that, if the need for such regulation can be demonstrated, the state medical society, education department, and health department cooperatively develop standards to be incorporated into the education law and enforced on all physicians of that state, thereby elim-

inating double standards for medical practice and restoring the licensing authority to the proper agency.

The AMA, on the basis of the data received from the state medical societies, (1) continue to identify the services that comprise good medical care; (2) develop guidelines that state and county medical societies may use in evaluating needs and priorities of medical services in their respective areas, and (3) ensure that these data and guidelines are widely distributed and publicized.

That the present structure of the association be retained and that it be strengthened by improvements and modifications in its function.

That on implementation of the program for organization and reorganization, a planning council with appropriate subcommittees be formed for the purpose of processing data and formulating policy recommendations for the consideration of the Board of Trustees and the House of Delegates.

Education: In December, 1968, the House agreed that "an ultimate goal is unification of the internship and residency years into a coordinated whole." To move closer to that goal, in this meeting the House adopted the following statements:

"After July 1, 1971, a new internship program shall be approved only when the application contains convincing evidence that the internship and the related residency years will be organized and conducted as a unified and coordinated whole.

"After July 1, 1975, no internship program will be approved which is not integrated with residency training to form a unified program of graduate medical education."

The House also adopted or approved essentials of approved programs in continuing medical education; essentials of an accredited educational program for histologic technicians; revision of essentials of approved internships and residencies pertaining to part-time apointments; essentials for approval of examining boards in medical specialties; revision of essentials of approved residencies in child psychiatry; revision of essentials of approved internships and residencies to add statement on employment relationship of house officers; revision of essentials of approved residencies in neurological surgery; revision of essentials of approved residencies in pathology; and revision of essentials of approved residencies in internal medicine.

A permanent Section on Neurological Surgery was created in the Scientific Assembly of the AMA.

Professional Liability: The House approved a Board report stating that liability insurance protection is essential so that physicians may continue to provide needed medical care to the public. "It has been concluded," the report said, "that the best way to provide such assurance is on a collective, rather than an individual basis, under programs jointly sponsored by the American Medical Association and the respective state medical association. . . . Minimum standards for an effective sponsored insurance program are being developed" and the Professional Liability Committee of the Board "is seeking with the insurance industry a means for instituting qualified insurance programs under such joint sponsorship with state associations which elect to participate."

Nurses and Other Allies: The following AMA position statement on nursing was adopted:

"The American Medical Association recognizes the need for, and will support efforts to increase, the number of nurses; recognizes the need for, and will facilitate the expansion of, the role of the nurse in providing patient care; encourages and supports all levels of nurse education; will promote and influence the development of a hospital nursing service, similar to a medical care service, under the leadership of a chief of professional service, aimed at increased involvement in direct medical care of the patient; supports the concept of the physician-led health team; and will seek constructive collaboration with the total nursing community."

The House also resolved that "the American Medical Association undertake a thorough investigation of a method to bring allied professions into a collaborative relationship with the AMA such as the establishment of a new class of membership;" and "that consideration be given to preparing 'essentials' for those categories of the allied health personnel groups which do not have them, and that the opportunity for vertical and horizontal mobility be considered in determining these 'essentials.'"

Convention Sites and Dates: The 122nd Annual Convention of the AMA, originally scheduled for July, 1973 in New York, has been changed to June 24-28. It will be in New York.

The Clinical Convention of 1972, originally planned for Atlanta, will be held in Cincinnati, Ohio. The 1976 Clinical will meet in Philadelphia.

This is the line-up now:

	Annual	*Clinical*
1970	Chicago	Boston
1971	Atlantic City	New Orleans
1972	San Francisco	Cincinnati
1973	New York	Anaheim
1974	Chicago	Portland, Ore.
1976		Philadelphia

Drugs: The House took a number of important actions in connection with drugs. Among them:

That the AMA "encourage Committees on Pharmacies and Therapeutics in each hospital to review drug reactions and related problems and to take appropriate control measures and to initiate informational programs."

That the AMA "seek passage of legislation for control of the manu-

facture and distribution of barbiturates and amphetamines."

That the AMA "expresses the concern of the medical profession that consumer protection be assured through more adequate surveillance of proprietary drug advertisements by private organizations and more effective cooperation in enforcement of applicable regulations by responsible governmental agencies."

That the AMA "supports dispensing by pharmacists of all medications in child-protective containers, and encourages acceptance of the containers by parents."

And that it is contrary to the public interest to repeal or modify "anti-substitution laws and regulations in order to permit the filling of prescriptions with therapeutic agents not intended by the prescribing physician." The House declared its intention "vigorously to support the maintenance and enforcement of antisubstitution laws and regulations."

Hospitals: The House resolved that "the terms 'negative,' 'within normal limits,' and 'normal' be approved by the JCAH as acceptable designations for use in hospital charts."

It also resolved:

That the AMA request the JCAH to specify that a Joint Conference Committee "include, where feasible, adequate representation from community-based physicians elected by the medical staff."

That the AMA reaffirm its position that "general practitioners should have the opportunity to practice medicine as active staff members in hospitals and should be granted privileges commensurate with their training and demonstrated abilities."

And that the AMA suggest that "medical staffs consider revising their respective hospital medical constitutions and bylaws to differentiate clearly between medical and administrative duties."

Miscellaneous: The House supported the Board's plan to establish a wholly owned, separate subsidiary corporation to engage in publication and possibly other related activities now carried on by the AMA in order to gain various economies, lower costs and better administrative and accounting procedures.

Delegates adopted a Board proposal to undertake a "Communications Program for the 1970's," consisting of television documentaries, educational advertising, media relations and other related activities "to improve public understanding and opinion of the profession."

Approval was given to Report A of the Judicial Council, which said, among other things, that "It is not in itself unethical for a physician to own a for-profit hospital or interest therein. The use the physician makes of this ownership or interest may, however, be definitely unethical. For example, for a physician to send a patient to such a hospital or to prolong a patient's stay in the hospital for his financial benefit would be unethical."

The bylaws were amended to permit osteopaths in military service to become service members of the AMA.

The House resolved to "support continuing efforts by the American Medical Association to inform the medical profession of the value and benefit to be realized from the implementation of adequate peer review programs" and directed the Board, the Council on Medical Service and "other appropriate sections of the AMA" to give this project "the highest priority and emphasize its urgency to all state and component medical societies."

Mindful of its obligation to protect public health, the House called on each state society "to take whatever steps are necessary to inform state legislators about the health hazards posed by the cult of chiropractic." It also encouraged medical schools "to include specific information in their curricula regarding the nature of the health hazard to individuals. . . posed by quackery in general and the unscientific cult of chiropractic in particular."

The House directed the AMA to make a detailed and comprehensive study and analysis of the methods and requirements for reporting infant mortality statistics "by those nations that are alleged to have a lower rate of infant mortality than that of the United States."

Delegates resolved that the AMA continue its efforts "to alert the American people. . . to the ever increasing health hazards of environmental pollution and to the urgent need for expanded research and effective control measures;" and that the AMA "further extend and intensify its present activities in pollution control and improvement of environmental health."

Considering the plight of prisoners of war in North Vietnam, the House recommended that, "in the best medical interests of both servicemen and their families, the World Medical Association and/or other appropriate international organizations be requested to use their influence with those countries which do not subscribe to the Geneva Convention to the effect that (a) a list of prisoners' names be furnished, (b) inspection of prisoner compounds by neutrals be carried out, and (c) medical supplies and food parcels, as well as mail, be distributed to prisoners."

Awards: Charles B. Huggins, M.D., of the Pritzker School of Medicine, Chicago, was presented the Dr. Rodman E. and Thomas G. Sheen Award at the opening session of the House, along with the check for $10,000 which accompanies the award.

Special awards were presented to the stars, creator and producer of the ABC-TV program, "Marcus Welby, M.D." Robert Young (who portrays Dr. Welby); James Brolin (who plays the assistant, Dr. Kiley); David Victor, creator and executive producer; and David O'Connell, producer, all received plaques in front of the House. The program and the people responsible for it were cited for portraying "the human understanding and uncompromising care which physicians give to their patients."

Also honored at the opening session of the House were the AMA winners in the 21st International Science Fair, whose exhibits were on display throughout the Scientific Assembly.

The winners were Beverly Fordham, a junior at Bryan Adams High school in Dallas: "Determination of Alpha Vigilance via Electroencephalography;" and Kevin Boran, senior at Lawton's Hill school in Pottsville, Pennsylvania: "Effects of Antidiuretic Hormone on Sweating Activity and Sweat Composition." ◄

SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis, Indiana 46208

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 13-15, South Bend, Indiana.

I propose to exhibit_____

_____

_____

Name_____

Address_____

City_____

State_____

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—June, 1970

Disease	June 1970	May 1970	Apr. 1970	June 1969	June 1968
Animal Bites	1313	1477	787	1153	1505
Chickenpox	111	471	459	247	185
Conjunctivitis	142	129	153	121	85
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	25	14	0	9	1
Gonorrhea	697	715	658	566	593
Impetigo	95	90	85	58	100
Infectious Hepatitis	46	80	49	41	56
Infectious Mononucleosis	56	121	71	49	53
Influenza	321	734	1244	368	189
Measles					
Rubeola	16	53	54	15	69
Rubella	117	351	442	193	63
Meningococcic Meningitis	1	5	2	6	8
Meningitis, Other	0	3	5	2	9
Mumps	191	337	314	236	234
Pertussis (Whooping Cough)	13	17	4	5	32
Pneumonia	275	482	390	146	180
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	460	844	861	386	458
Syphilis					
Primary & Secondary	35	35	40	34	25
All Other Syphilis	150	168	108	131	142
Tinea Capitis	7	1	5	2	13
Tuberculosis (Active)	73	76	112	97	128

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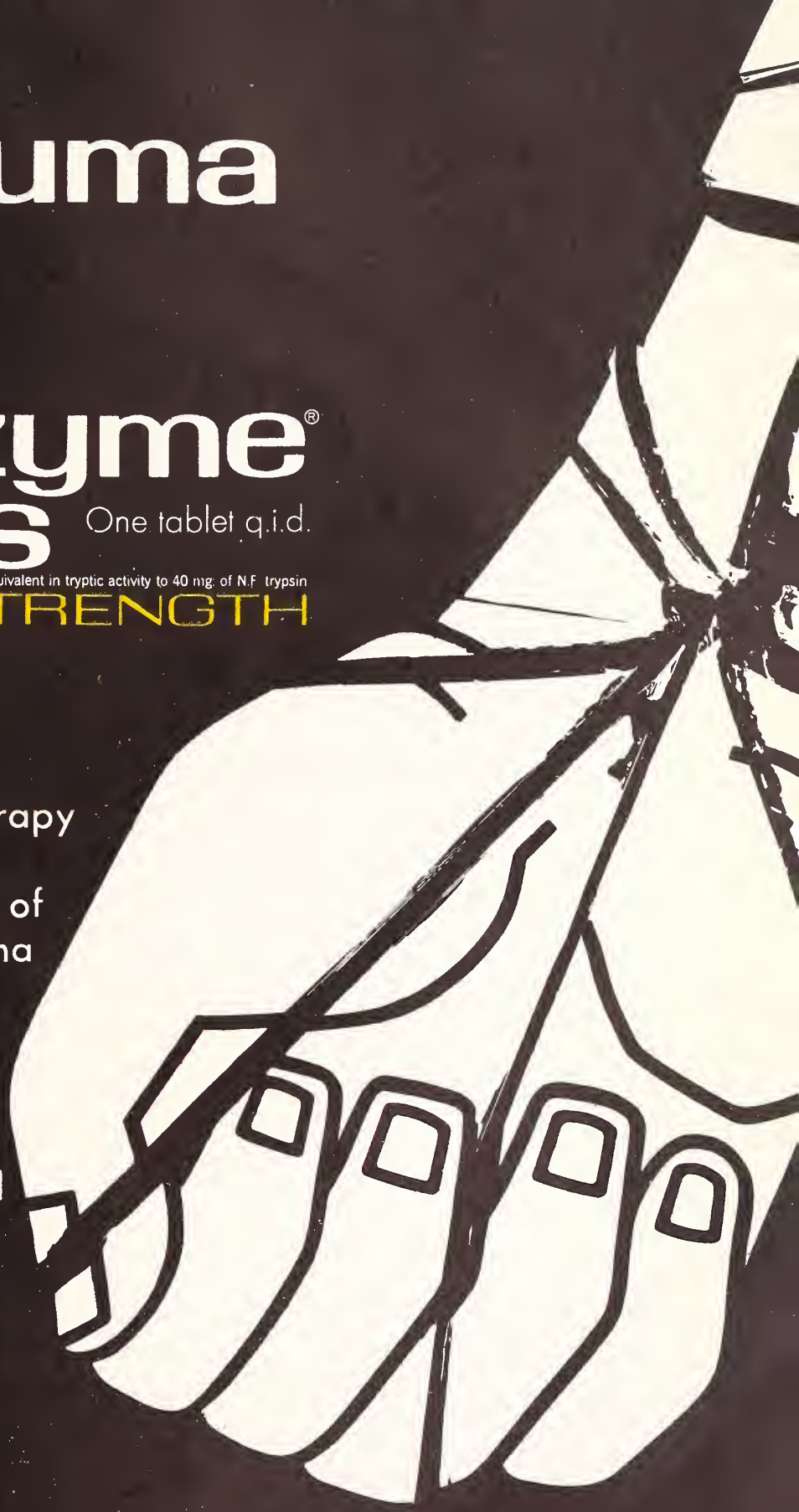
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new Orenzyme® Bitabs

One tablet q.i.d.

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units.; equivalent in tryptic activity to 40 mg. of N.F. trypsin

DOUBLE STRENGTH



Proteolytic enzyme therapy specifically indicated for the rapid resolution of inflammation and edema as adjunctive therapy in accidental and surgical trauma.

1 tablet q.i.d. provides recommended therapeutic dose at lower cost.



Description: ORENZYME BITABS offers the therapeutic effects of trypsin in an oral form as adjunctive therapy for the rapid resolution of inflammation and edema. ORENZYME BITABS is convenient to use, promotes patient cooperation and is ideally suited for maintenance therapy following parenteral trypsin.

Indications: When used as adjunctive therapy for the rapid resolution of inflammation and edema, good results have been obtained in:

- ☐ Accidental Trauma
- ☐ Postoperative Tissue Reactions.

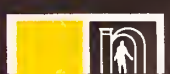
Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

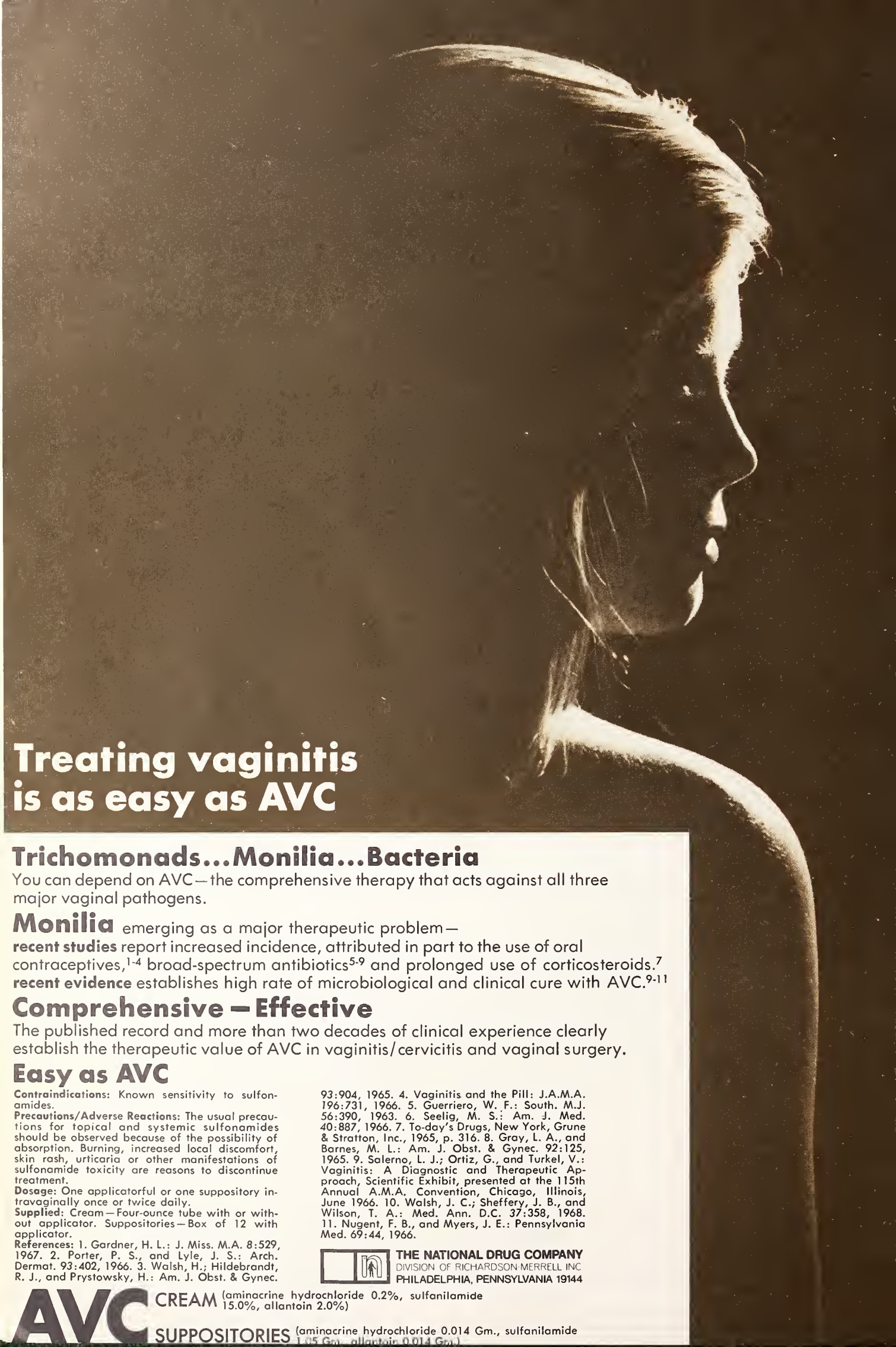
Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia,

Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

Dosage: One tablet q.i.d.



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Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

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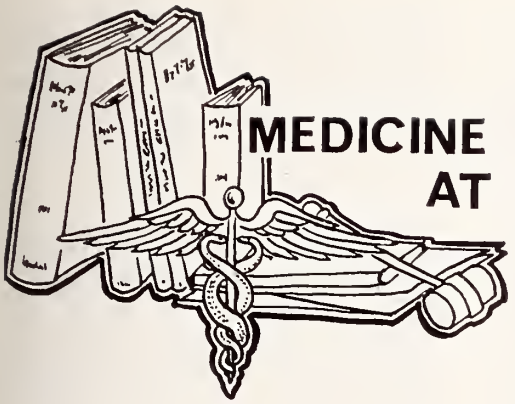
Contraindications: Known sensitivity to sulfonamides.
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Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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MEDICINE AT LAW

Diet Pills Not Cause of Emotional Distress—A physician was not liable to a waitress who claimed that she became emotionally distraught and attempted suicide because he prescribed an overdosage of diet pills. The weight control specialist testified that his prescription was correct and that her problems were unrelated to his treatment.

The woman contended that the physician did not perform proper diagnostic tests before he prescribed the pills. She also alleged that the name on the container of pills was that of another patient, indicating that she had received medicine intended for someone else. The physician claimed that an error had been made in labeling the medicine but that she was given the correct preparation.

The waitress charged that, as a result of the allegedly negligent treatment, she became emotionally upset, had a constant feeling of being "high," and developed a skin disorder which did not clear up for eight months. A physician who testified on her behalf said that these problems could have been caused by taking an excessive number of diet pills, but he commented that the weight control specialist had used reasonable care in prescribing the dosage.—*Fontenot v. Tracy*, Super Ct., San Diego Co., Docket No. 309672 (Cal., 1970).

Neurosurgeon Held Not Liable for Stroke Following Angiogram—In the absence of medical proof of negligence, a physician is not liable for a stroke following an angiogram, a Texas appellate court ruled. The trial court judge had instructed the jury to return a verdict for the neurosurgeon. The patient and her husband appealed the result.

For approximately ten months, the patient had been under the care of a physician. She complained repeatedly of severe headaches and noises in her ear. The physician transferred her to a hospital, where she was placed in the care of a neurosurgeon.

The neurosurgeon conducted a series of tests, including ordinary skull x-ray, brain scan, spinal tap, and an echoencephalogram. The skull x-ray indicated a pineal shift of five millimeters. From these tests, the neurosurgeon concluded that an angiogram was necessary, and the patient's physician agreed with this conclusion. A few hours after the angiogram, the patient suffered a stroke which paralyzed her right side.

At the trial, the patient contended that the neurosurgeon had not fully informed her of the risks involved in the angiogram. However, there was no evidence that he did not disclose the facts, and the neurosurgeon himself testified that he had warned her of the possibility of a stroke. Since there was no evidence introduced by the patient on this question, the Texas appellate court agreed with the trial court's decision that there was no issue of negligence for the jury to decide.

The patient also argued on appeal that the trial court should have permitted the jury to decide the case on its own on the theory of *res ipsa loquitur*. The Texas appellate court noted that in its jurisdication the doctrine of *res ipsa loquitur* is rarely applied in malpractice cases involving the results of a medical procedure. Even if this case had been one where *res ipsa loquitur* should have applied, the trial court's failure to do so would have been harmless error, because the patient's own medical witness testified that the proper procedure would have been to advise an angiogram.

Since there were no issues for the jury to consider in this case, the trial court correctly instructed the jury to bring in a verdict for the neurosurgeon.—*Stinnett v. Price*, 446 S.W. 2nd 893 (Tex., Sept. 29, 1969; rehearing denied, Nov. 3, 1969).

Physicians Held Liable for Safety Pin Left in Abdomen—Two Oregon physicians were held liable for damages resulting from a safety pin left in a patient's abdomen during an operation. The jury returned a verdict for the patient against the hospital and the physicians. Only the physicians appealed the verdict, and the Oregon Supreme Court upheld the jury verdict.

On appeal, the physicians argued that the doctrine of *res ipsa loquitur* should not have been applied because they lacked the exclusive control necessary for the application of the doctrine. They urged that it was the duty of the nurses employed by the hospital to take care of the safety pins.

The Oregon Supreme Court rejected this argument, noting that it is well settled that a foreign object left in a patient's interior during surgery is a basis for a malpractice suit. The only way the physicians could have avoided liability was to prove conclusively that the safety pin had been placed in the abdomen in such a man-

ner that the physicians could not have known about it or could not have discovered it in the exercise of reasonable care. No such proof was offered at trial.—*Nicholson v. Sisters of Charity of Providence*, 463 P.2d 861 (Ore., Jan. 21, 1970).

Refusal of Hospital to Admit Patient After Emergency Treatment—When a patient is given proper emergency room treatment after an accident and his condition is such that immediate admittance to the hospital is not necessary, a hospital may refuse admittance if the patient has nothing to offer for the purpose of assuring payment of hospital bills, a Louisiana appellate court has recently held.

The patient was in an automobile accident and was taken to the hospital emergency room, where he was properly treated for multiple deep facial lacerations, a possible head injury, traumatic damage to the teeth, and multiple bruises and contusions of the body. While the patient was in the emergency room, his wife was asked for a $100 deposit for the purpose of admitting the patient into the hospital. It was at her request that the patient was then transferred to a V.A. hospital.

The court held that it was the hospital's policy and practice to admit and treat immediately any patient whose condition was such as to require immediate admission and treatment. However, this patient's condition did not require such admission as an emergency measure. The requirement of a deposit prior to hospital admission was the usual procedure among private hospitals in the area where, as here, the patient has nothing to offer for the purpose of assuring payment of the bills. In the absence of an immediate need for emergency hospital treatment, the requirement of a deposit prior to hospital admission was neither unreasonable nor improper.—*Joyner v. Alton Ochsner Medical Foundation*, 230 So. 2d 913 (La. Ct. App., Feb. 2, 1970).

Production of Hospital Committee Minutes Denied—A motion seeking production of minutes and reports of any hospital board or committee or staff concerning the death of a patient and all reports pertaining to the patient, including those concerning the hospital's malpractice insurance carrier, was denied by the federal trial court in the District of Columbia. The decision on the motion grew out of a suit for negligence against the hospital and several physicians.

The medical audit function is performed by hospital committees solely to improve care through self-analysis, the court said. Audit is also required by the Joint Commission on Accreditation, whose denial of accreditation can substantially affect a hospital's professional standing. The court noted that "Candid and conscientious evaluation of clinical practices is a *sine qua non* of hospital care."

"Confidentiality is essential to effective functioning of these staff meetings," the court continued, and "constructive criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit." There is an "overwhelming public interest in having these staff meetings held on a confidential basis," and the minutes are entitled to a qualified privilege, the court declared.

A second basis for the court's holding was indicated in its statement that in the absence of "extraordinary circumstances" no good cause was shown why the minutes should be disclosed. What someone later thought of the handling of a case is not relevant to the case.

Reports between the hospital and its malpractice carrier subsequent to the filing of the lawsuit are for the purpose of preparing the insurance company's lawyer for trial and, therefore, are part of the attorney's "Work product" and not subject to discovery. —*Bredice v. Doctors Hospital, Inc.*, Civil Action No. 3118-67 (D.C., D. of C., March 10, 1970.)

Medical Personnel Denied Ruling on Alcohol Blood Tests—Medical personnel were denied their request that a court determine their future rights and liabilities with regard to taking blood tests to determine alcohol content. The denial was affirmed by the Wisconsin Supreme Court.

The case was brought by a hospital and its staff against the law enforcement officers of a Wisconsin county and the state highway patrol. The trial court denied the relief sought, and the Wisconsin Supreme Court upheld this ruling.

The medical personnel complained that a police officer ordered a physician to take a blood test under threat of prosecution. They stated that they could also become liable if the person upon whom the test is made decides to sue. Since this type of situation recurs, the medical personnel asked the court to determine in advance their rights and liabilities in all such future cases.

On appeal, the Wisconsin Supreme Court noted that the United States Supreme Court has stated that the lawfulness of each situation involving a blood test must be determined individually because the circumstances are always different. For example, if an arrest has been made, if there is probable cause to believe the person arrested is intoxicated, and if the person does not object to the blood test for religious reasons or out of fear for his personal safety, a blood test may be lawful under the United States Constitution. However, if one of these elements is missing or some other circumstance arises, the blood test may violate the person's constitutional right against unlawful search and seizure.

Therefore, the Wisconsin Supreme Court ruled that the trial court properly denied the relief sought because it would be impossible to predict the surrounding circumstances of every future situation involving a blood test. The court also noted that the police officer's threat of prosecution was not provided for under Wisconsin law.—*Waukesha Memorial Hospital, Inc. v. Baird*, 173 N.W.2d 700 (Wis. Sup. Ct., Feb. 3, 1970).

Malpractice in the Hospital Operating Room—Negligence occurring in hospital operating rooms and leading to malpractice suits was discussed in a legal periodical. Over 75% of the doctors sued for malpractice are surgeons. Approximately 80 to 90% of such causes of action find their origin in the operating room or incidents directly traceable to the operating room suite.

The author contends that the great majority of operating room mishaps resulting in malpractice suits concern death in the operating room, absence of a recovery room or mishaps therein, missing instruments or sponges, explosions in the operating suite, anesthesia mortality, infections, surgery performed on the wrong patient, and improper consent to surgery.

The author advances a number of ways in which the possibility of a malpractice suit can be reduced. Before the patient enters the hospital, the doctor should emphasize to the patient that the hospital care and treatment is under his supervision and an extension of the treatment the doctor has instituted in his office. When the doctor visits the patient at the hospital after admission, he should tell him the medical plan for the diagnosis and treatment of the illness, disease, or injury. If special tests are to be taken the patient should be informed of them and given the reasons for their being taken.

During the patient's hospital stay the doctor should act as the mediator beween the patient and the hospital. These courtesies enable the patient to understand more lucidly the hospital routine and, thereby, the patient tends to minimize complaints.

The hospital, to be surgically safe and legally protected, must always be on the alert to the constant threat of the sources of malpractice and negligence in the operating suite. A preventive operating room program should be set up, centered about adequate nursing supervision of the surgical suite, and containing an up-to-date modern equipped department of anesthesia with a full time M.D. anesthesiologist in charge of both anesthesia and recovery room.

The recovery room should be under the immediate surveillance of a registered nurse supervisor. A complete and properly functioning intensive care unit, as part of the recovery room or as a separate section, should be available under proper medical and nursing supervision for the seriously ill postsurgical patient. Cardiac arrest teams, available for immediate activation, with the most facile implementation possible, should be available. Proper postoperative nursing care, with written instructions from the surgeon to the nurse explicitly spelled out, is also a potent weapon against the accusation of negligence.—*Hospital Operating Room and The Law*, by Bernard J. Ficarra, 16 Medical Trial Technique Quarterly, No. 1, p. 13 (Sept., 1969), published by Callaghan and Company, 165 North Archer Avenue, Mundelein, Illinois 60060.

$140,000 Settlement Reached in Hospital Case—In an action against a hospital by the widow and children of a patient for failure of the hospital to provide appropriate care while the patient was suffering a heart attack, a settlement was agreed to in the amount of $140,000.

The patient awoke one morning with severe chest pains and had difficulty breathing. He was taken to the hospital by his wife and oldest daughter and was examined by the resident on duty. He was given an electrocardiograph test which was read as "questionable," and digitalis was prescribed. He was then told to return to the hospital the next day or go to another hospital which had better facilities. On the way home from the hospital his condition grew worse and he died at home the same morning.

The widow and family brought suit against the hospital for $300,000. They contended the deceased was in the process of having a heart attack while being examined and that he should have been hospitalized to care for and treat his condition. It was determined that the resident who examined him was not a full-time resident at the hospital but was in fact "moonlighting" while acting as a full-time resident at another hospital.

The hospital contended that the patient had been suffering from a severe case of the flu prior to the morning he went to the hospital and that this condition masked the heart attack and made it impossible for the resident to determine that a heart attack was occurring. The hospital further contended that since the autopsy showed the attack to be massive, and since there was evidence of an apparent prior heart attack, not known to the deceased, which had caused damage to the heart muscle, there was no assurance his life could have been saved even if he had been hospitalized.

During settlement talks, the hospital and family agreed to a settlement of $140,000.00.—*Lucero v. Kaiser Foundation Hospitals*, Docket No. R.15178, Contra Costa County (Cal., 1970).

Doctor-Patient Privilege Inapplicable to Child Abuse—The hospital records of a mother and her newborn child are not protected from the confidentiality of the doctor-patient privilege when such evidence

relates to child abuse, a New York Family Court has ruled.

The hospital records of the mother indicated that she had been injecting ten "bags" of heroin daily into her blood stream and that she had administered a dose to herself four hours before delivery of her baby. The attending doctor testified that her baby was born normally and without apparent symptoms until 24 hours after birth and that then the baby began to exhibit the unmistakable narcotic symptoms: preconvulsive tremors, hyperactivity, incessant crying, and ravenousness alternating with vomiting. Sedatives (phenobarbital), dark and quiet were required for seven days before the child became physically well. Without careful therapy, the child might have suffered convulsions and death.

The applicable statute permitted children to be removed from the custody of a parent "adjudicated a narcotics addict." The Family Court held that in a petition alleging abuse it could first rule on the narcotics addiction and then proceed to the question of abuse. The court further held that hospital records revealing narcotics addiction could be used even though the mother had not waived the doctor-patient privilege because in a child-abuse hearing the welfare of the child is paramount.—*In Re John Children,* 306 N.Y.S.2d 797 (N.Y., Family Court, Dec. 12, 1969).

Paternity Not Established by Issuance of Birth Certificate— In a proceeding to determine heirship, the issuance of a birth certificate naming the deceased as father is not sufficient to prove paternity and allow the illegitimate child to inherit from the estate of her alleged father, the highest court of Indiana held.

The child was born illegitimate. The mother instituted bastardy proceedings against the purported father, the person to whose estate the alleged child now seeks to be designated an heir. The proceeding was dismissed when the mother accepted $200.00.

The controlling statute states that for an illegitimate child to inherit as if she were the legitimate child of her father, the paternity of such child must be established by law during the father's lifetime.

The court interpreted the statute as meaning that the child's paternity must be determined in a judicial proceeding brought for that purpose in a court of law having jurisdiction to determine the issue. The bastardy proceeding was not sufficient to meet this requirement because that action was dismissed before trial, and once a suit has been dismissed the situation is just as though the suit has never been filed.

The court also ruled that the issuance of the birth certificate listing the alleged father was not sufficient to establish paternity under the statute. The issuance of a birth certificate is not a "judicial proceeding" as required by the statute, but is, at best, a ministerial act by and on behalf of the State Board of Health. Since paternity was not established by law within the father's lifetime, the child was unable to inherit from her alleged father.—*Burnett v. Camden,* 254 N.E.2d 199 (Ind. Sup. Ct., Jan. 13, 1970).

Mentally Retarded Confined Until Able To Stand Trial—Confining one accused of crime in a mental hospital until such time as the appropriate state department certifies that he is sane is not unconstitutional, even though the confinement may be for the remainder of the accused's life, the highest court of Indiana held.

The accused was a deaf mute, and the psychiatrists who examined him found him to be illiterate and unable to learn sign language or learn sufficiently to bridge the communication gap.

The psychiatrists reported that the accused robber could neither understand the nature of the charges against him or adequately participate in preparing his defense. They further concluded that if the accused were to gain sufficient comprehension to stand trial it would be only as a result of developing a means of communication, but there was some doubt that he would even then be able to comprehend the nature of the charges.

The court held that committing the accused to the Division of Mental Health and permitting that department to choose the appropriate facility for confinement was proper, and that the choice of the institution lies within the professional and expert judgment of members of the department.

The fact that the accused may never improve to the extent that the department could certify that he is able to stand trial was held not to violate his rights under the constitution, although this may result in confinement for the remainder of his life.

The legislation creating the power to confine the mentally defective, retarded or insane is a proper exercise of the police power of the legislature to provide for the safety, health, and general welfare of the public, the court concluded.—*Jackson v. State of Indiana,* 225 N.E.2d 515 (Ind. Sup. Ct., Feb. 19, 1970). ◄



ABSTRACTS, BOOK REVIEWS

THE COMPLETE DIRECTORY OF MEDICAL AND HEALTH SERVICES

Jessyca Russell Gaver, Universal Publishing and Distributing Corporation, New York, 1970; 281 pages; 95¢.

A most complete directory of health and medical problems, this paperback is written in interesting fashion and in language suitable for the general public.

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FRANK B. RAMSEY, M.D., Editor
Indianapolis

MANIC DEPRESSIVE ILLNESS

George Winokur, A.B., M.D.; Paula Clayton, B.S., M.D.; Theodore Reich, B. Sc., M.D., C.V. Mosby Co., St. Louis, 1969; 180 pp.; $6.50.

This small monograph is a review of the vast literature which has accumulated on this serious mental illness. The authors are all associated with Washington University School of Medicine.

The clinical picture of this disorder is clearly described and the diagnostic features are considered in detail. Studies of etiology are reported and heredity is given special consideration. The information presented in the book will aid the physician in differentiating this bipolar disease from other less definite forms of depression (unipolar psychosis). There are some important aspects of the disease not generally recognized. Follow-up studies indicate that these patients are a serious social problem, with which the physician should be familiar. A great number of these patients commit suicide or are involved in crimes. The disease usually occurs in higher socio-economic groups—this is especially true of females.

In the discussion of etiology, endocrine, biochemical and electrolyte studies, there are reports without conclusive findings. Considerable discussion is given to the hereditary aspects and it is considered to be linked with X chromosome which also carries color-blindness. Several family charts are included.

Extensive and useful information is given regarding treatment which is complicated because the illness is phasic, episodic and frequently self-limited. The age of onset of the illness as reported in the literature has been reviewed by these authors who found it may occur in the late teens and also over 70—but rarely.

The chapter on therapy is quite comprehensive covering institutional care, drugs and electroconvulsive therapy. Special interest in drug therapy has lately been accorded to lithium carbonate. The drug was originally used as a salt substitute. Extensive experience with it is reported in this book. It is generally believed to be valuable but not free of side effects.

Obviously the recommended treatment depends on the phase of the disturbance. If the patient shows any suicidal tendencies, institutional care is imperative.

At the end of each chapter there is a copious collection of references which amount to a complete bibliography on the subject.

This book is especially for psychiatrists and other physicians interested in mental disorders. It is easy to read and has an ample index.

DAVID A. BICKEL, M.D.
South Bend

PROGRESS IN THIN-LAYER CHROMATOGRAPHY AND RELATED METHODS

Vol. I., edited by Alois Niederwieser and Gyorgi Pataki, Ann Arbor-Humphrey Science Publishers, Inc., 1969; 224 pages with numerous illustrations, seven chapters and an excellent appendix plus a glossary pinpointing exact meaning; $15.00.

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As usual, the printing and binding are excellent; the glossary is all to the good; the conversion of Rf values to Rm in the appendix is unique: altogether a real gourmet feast for the expert!

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

Abstracts From Various Literature, Prepared by AMA

SERIAL OBSERVATIONS IN PATIENTS WITH RENAL DISEASE AFTER ANALGESIC ABUSE

T. Nitsche and K. D. Bock (Klinikum Essen der Ruhr-Universitat, Essen, West Germany)

Deutsch Med. Wschr. 95:927-934, (April 24), 1970.

The course of renal disease was assessed in 25 of 30 patients in whom renal involvement was the result of phenacetin abuse. Clinical cure of the renal disease was never observed. Two of nine patients, who had stopped taking phenacetin after the first examination, showed some improvement. In the others, there was no definite evidence of progression. Ten patients continued to take phenacetin in high doses; in four others this was questionable. None of these patients had any definite, but six others had marked, worsening of their renal disease. The six deaths were all among patients of this group. Two other patients died within seven weeks of the initial medical examination.

CARDIAC ARREST: EXPERIENCE AND RESULTS IN EMERGENCY TREATMENT OUTSIDE OPERATING THEATER

T. C. Dixon (Royal Adelaide Hospital, Adelaide, Australia)

Med. J. Aust. 1:754-759, (April 11), 1970.

Emergency calls were made to 171 patients; 124 were between 50 and 69 years of age, the majority between 60 to 69 years (58 cases). The precipitating causes of cardiac arrest were as follows: 96 or 56% followed myocardial infarction, with a further 32 or 18.6% the result of other acute cardiovascular phenomena. In arrest related to myocardial infarction, ventricular fibrillation was twice as common as asystole. Complete recovery, however, was very similar with either state. Unless adequate circulation of oxygenated blood to the brain is reestablished within three minutes after arrest at normal body temperature, irreversible cerebral damage will result. There have been 35 misguided attempts to resuscitate a patient who had simply died as the inevitable endpoint in a chonic, incurable illness. That the use of closed chest cardiac massage and the subsequent intensive management of cardiac arrest can have a completely successful outcome has been established beyond doubt. Twenty-seven, or 16%, of the patients recovered completely to leave hospital, intact neurologically.

EVALUATION OF ROUTINE PROFILE CHEMISTRY SCREENING OF ALL PATIENTS ADMITTED TO COMMUNITY HOSPITAL

R. E. Belliveau, J. E. Fitzgerald, and D. A. Nickerson (Salem Hospital, Salem, Mass.)

Amer. J. Clin. Path. 53:447-451, (April), 1970.

A follow-up study of 1,046 patients in a community hospital was conducted to evaluate the significance of new data uncovered in a routine profile chemistry screening consisting of 18 different tests. Of the patients screened, 4% had alternative or new diagnoses established, related to the finding of "abnormal" profile values. Overall, 43.2% of the total profiles were found to be abnormal, but more than 70% of these were accounted for by past or presently diagnosed conditions. The greater proportion of the abnormal profiles and new findings secondary to these occurred in patients on the medical service. The most frequently encountered abnormal chemistry values were those of uric acid, glutamic oxalacetic transaminase, glucose, and lactic dehydrogenase.

CLINICAL COURSE OF ULCERATIVE PROCTOSIGMOIDITIS

F. W. Nugent et al. (Lahey Clinic Foundation, Boston)

Amer. J. Dig. Dis. 15:321-326, (April), 1970.

Ulcerative colitis confined to the rectum or rectum and sigmoid was studied in 234 patients. During a prolonged period of follow-up, the clinical course was extremely benign when compared with that experienced by patients with the diffuse form of the disease; there was a minimum of morbidity and there were no deaths. Only ten patients required operation on the colon to control the disease. Extracolonic manifestations were virtually absent and no malignant degeneration occurred. The authors believe that this disease is part of the spectrum of ulcerative colitis but that its anatomic confinement to the distal colon allows prediction of a much more benign clinical course.

LAWN MOWER INJURIES IN CHILDREN

J. L. Grosfeld, T. S. Morse, and E. J. Eyring (Children's Hospital, Columbus, Ohio)

Arch. Surg. 100:582-583, (May), 1970.

Seventeen power lawn mower injuries in children are reported. Three distinct patterns of injury were observed. Bystanders were injured either by falling under a mower or by missiles hurled at them by the rotating blades. Young operators suffered maiming injuries by inserting hands or feet under the blades of walking mowers. The most devastating injuries affected children who fell from the laps of parents operating tractor type mowers. All of these severe injuries were preventable.

CEPHALOSPORINS: MICROBIOLOGICAL, CHEMICAL, AND PHARMACOLOGICAL PROPERTIES, AND USE IN CHEMOTHERAPY OF INFECTION

L. Weinstein (171 Harrison Ave., Boston) and K. Kaplan

Ann. Intern. Med. 72:729-739, (May), 1970.

Cephalothin and cephaloridine, semisynthetic congeners of cephalosporin C, are highly active against nearly all gram-positive bacteria (except enterococci and methicillin-resistant staphylococci) and, at concentrations of 1 g to 10 g/ml, against most strains of *Salmonella, Shigella, Klebsiella, Proteus mirabilis,* and many *Escherichia coli,* paracolon bacteria, and *Hemophillus in-*

fluenzae. These drugs are inactivated by a beta lactamase, cephalosporinase, and are susceptible to very high concentrations of penicillinase. They inhibit cell wall synthesis. Neither cephalothin nor cephaloridine is absorbed from the gastrointestinal tract. Two related compounds, cephaloglycine and cephalexin, are absorbed by this route. They are largely excreted by the kidneys. In the presence of renal disease the dose of each must be reduced. Cross-sensitization between penicillin and the cephalosporin C congeners is very uncommon and not an important contraindication to the use of these agents in individuals allergic to penicillin. Cephalothin may produce Coombs'-positive reactions. Doses of cephaloridine greater than 4 gm/day may lead to renal dysfunction or acute tubular necrosis.

APATHETIC THYROTOXICOSIS: DISTINCTIVE CLINICAL AND LABORATORY ENTITY

F. B. Thomas, E. L. Mazzaferri (Ohio State University Hospital, Columbus, Ohio), and T. G. Skillman

Ann. Intern. Med. 72:679-685, (May), 1970.

Nine patients with apathetic thyrotoxicosis were studied over a one-year period and compared with 29 typical hyperthyroid subjects. These apathetic patients were significantly older and had a longer duration of symptoms and greater weight loss. The study group had a rather typical apathetic, placid or depressed appearance often thought to represent "old age depression." Cardiovascular symptoms, atrial fibrillation, and congestive heart failure were common. They typically had evidence of a moderately severe proximal myopathy. Thyromegaly, while usually present, was not prominent and was usually multinodular. There was a striking absence of eye signs generally associated with thyrotoxicosis, while blepharoptosis was frequently observed. Although the protein-bound iodine and ^{131}I thyroidal uptake were not markedly elevated, the diagnosis was easily established by utilizing the usual tests of thyroid function and evaluating the rather typical clinical features.

ACCUMULATION OF BARBITONE IN PATIENTS ON REGULAR HEMODIALYSIS

J. S. Cameron et al. (Guy's Hospital, London)

Lancet 1:912-914, (May 2), 1970.

Barbital was found in concentrations of 0.24 to 1.32 mg/100 ml in the blood of six patients on regular hemodialysis. None of the patients had apparently taken the drug, but all had taken other barbiturates. Barbital was not found in plasmas from five patients on dialysis who had not taken any barbiturates, nor from a patient taking phenytoin. Contamination of the pentobarbital capsules used by 0.1% to 0.2% barbital was the most likely source. Some barbital was found in all of 20 samples of pentobarbital from different manufacturers. Accumulation seemed to depend on strong binding of the barbital to plasma proteins, principally albumin, which was demonstrated both in vitro and in vivo. This binding reduced the dialysance of barbital in standard Kiil dialysis by 50%. The accumulation of normally insignificant contaminants or metabolites in patients with renal failure or on dialysis must be considered.

ARTERIAL BLOOD GASES AND ACID-BASE BALANCE AT EXERCISE BREAKING POINT

R. Gilbert and J. H. Auchincloss, Jr. (750 E. Adams St., Syracuse, N.Y.)

Arch. Intern. Med. 125:820-824, (May), 1970.

Arterial blood gas analyses at the exercise breaking point were performed on eight normal subjects, eight patients with valvular heart disease, nine subjects with chronic obstructive airway disease, and four patients with severe dyspnea unexplained by organic disease (exercise hyperventilation group). Normal subjects demonstrated the most severe metabolic acidosis at the breaking point; patients with cardiac and pulmonary disease showed lesser degrees. The exercise hyperventilation group had a respiratory alkalosis at the breaking point. Arterial oxygen partial pressure was higher at the breaking point than at rest in normal subjects, patients with heart disease, and in the group with hyperventilation with exercise. In patients with pulmonary disease, arterial oxygen partial pressure usually fell with exercise. Arterial blood gas analysis at the exercise breaking point provides useful information concerning the physiological state.

MALIGNANT LYMPHOMA ASSOCIATED WITH HYDANTOIN DRUGS

J. A. Anthony (Cincinnati General Hospital, Cincinnati)

Arch. Neurol. 22:450-454, (May), 1970.

A retrospective necropsy study covering 11 years revealed a tenfold increase over the expected incidence of malignant lymphoma in epileptic patients receiving long-term hydantoin therapy. This suggests but does not prove that lymphoma is caused by hydantoins. Patients on the hydantoin drugs bear careful watching for signs of the lymphomatous process, one reason for checking the white blood cell count on occasion.

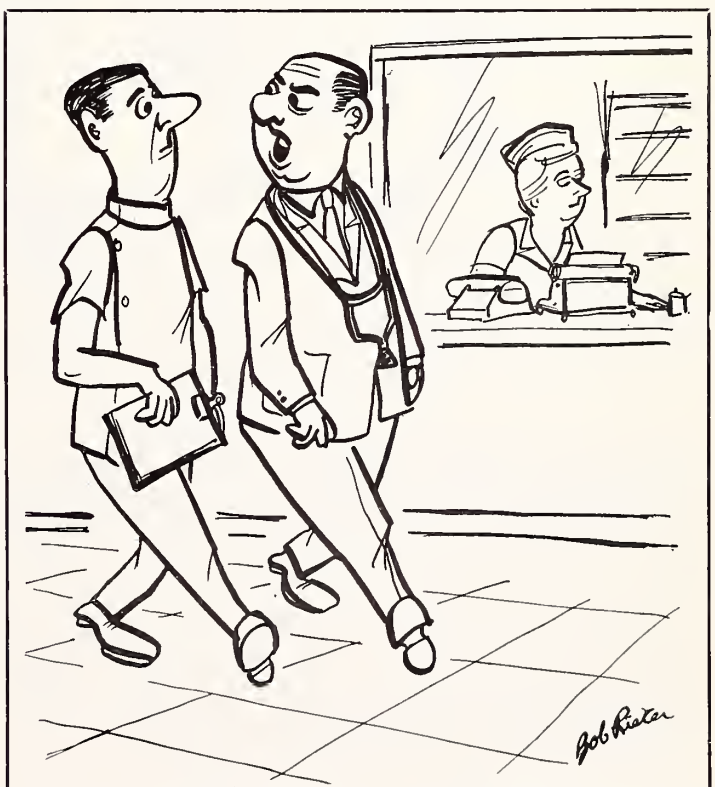
EPIDEMIOLOGICAL STUDY OF WORKERS PRODUCING ENZYME WASHING POWDERS

M. L. Newhouse et al. (School of Hygiene and Tropical Medicine, London)

Lancet 1:689-692, (April 4), 1970.

A survey was made of factory workers making detergents containing "alcalase," a proteolytic enzyme prepared from *Bacillus*

Continued



I know you like the authoritative sound of your own voice, Frobisher, but for heaven's sake, stop shouting "Prepare for surgery" when a patient comes in with a sprained ankle!

subtilis. Twenty-one percent of those examined gave a direct positive reaction to prick test with alcalase. More than twice as many of those sensitized to alcalase than of the unsensitized also reacted to common allergens. The predominant symptoms of the affected were nasal irritation and attacks of cough, wheezing, or difficult breathing. Tests of ventilatory capacity showed evidence of obstructive bronchial disease in the sensitized group. The sensitized workers with respiratory symptoms showed a significantly greater fall in FEV during the work shift than sensitized men without symptoms and the unsensitized. Substantial improvements in the manufacturing process reduced the levels of enzyme in the air in workrooms. Six months after the first survey, comparable groups of sensitized and unsensitized workers were reexamined. There was no evidence of deterioration in the ventilatory capacity of either group. Pulmonary diffusion tests of two affected men did not reveal any firm evidence of interstitial pulmonary disease.

POMADE ACNE

G. Plewig, J. E. Fulton, and A. M. Kligman (3600 Spruce St., Philadelphia)

Arch. Derm. 101:580-584, (May), 1970.

Seven hundred and thirty-five adult men were examined with regard to the daily use of scalp creams and oil. About 70% of long-term users of pomades displayed a recognizable acneiform eruption of the forehead and temples consisting mainly of rather uniform closed comedones with occasional papulae-pustules. The more elaborate formulations (Noxzema, Dixie Peach, and Wildroot) induced pomade acne more frequently and more intensively than simpler preparations like mineral oil and vaseline. Applications of five pomades to black skin under continuous occlusion for eight weeks produced microscopic comedone formation. Histologically, pomade acne was undistinguishable from acne vulgaris.

GRAM-NEGATIVE PNEUMONITIS: A NEW POSTOPERATIVE MENACE

M. Atik and B. Hanson (VA Hospital, Louisville)

Amer. Surg. 36:198-204, (April), 1970.

The six patients reported in this series had pneumonitis caused by gram-negative organisms, *Pseudomonas aeruginosa, Aerobacter aerogenes*, or both. There were complications of shock and hypotension and marked respiratory difficulties in almost all of the patients and bleeding tendencies in four instances. The complications occurred suddenly, early in the postoperative period, in patients who were not especially debilitated and had no significant preexisting chest abnormalities. All instances occurred following uncomplicated surgical procedures and were seen with a period of less than two months in an epidemic form. In four of the six patients, similar gram-negative organisms were traced to respirator apparatus used during anesthesia, and in one patient to the apparatus in the intensive care unit.

INCIDENCE OF ASPIRIN INGESTION IN PATIENTS WITH PEPTIC ULCER

J. M. Duggan (Royal Newcastle Hospital, Newcastle, Australia) and B. L. Chapman

Med. J. Aust. 1:797-800, (April 18), 1970.

To elucidate the cause of the excessive incidence of gastric ulcer in women in eastern Australia, 170 patients with uncomplicated peptic ulcer examined in one medical unit were studied. The excessive incidence of gastric ulcer was in women aged 30 to 59 years. There was a statistically significant association between gastric ulcer and the consumption of large quantities of aspirin containing preparations, usually APC powders taken for headache. No such correlation for duodenal ulcer in either sex or gastric ulcer in men, was found. Geographical differences in analgesic habit may explain the interstate variations. ◄

UPJOHN WINS ANOTHER ROUND IN PANALBA CASE

Upjohn Company has won another round in its contest with the Food and Drug Administration to keep its antibiotic Panalba (tetracycline and novobiocin) on the market. After first allowing Upjohn to continue sale of the product under altered labeling, as no safety issue was involved, FDA later ordered the drug off the market on the grounds of a hazard. Upjohn obtained injunctive relief so the product could still be available.

In the latest step, a Federal judge in Kalamazoo, Michigan, granted a restraining order (or injunction) that goes beyond the first restriction on FDA's authority. He said it is clear that there is no public health hazard in continued sale of Panalba, and that Congress did not intend that FDA handle such issues in an arbitrary manner. The effect is that Upjohn can continue to sell the product for 30 days after FDA decides whether to grant a hearing on the issue.

Earlier, FDA rejected the appeal for a hearing, saying that it was barring the drug as a protection to patients. If a hearing now is granted, sale of Panalba will continue until conclusion of the hearing. If FDA again rules out a hearing, Upjohn has several legal options to use in an attempt to keep Panalba available to physicians and patients.—*PMA Newsletter.*



Vell, Dr. Cunningham! I was just telling Herbert should talk to you about my allergy. 'irst my nose starts to tickle and..."

u know the rest of the story. Sneezing. Watery eyes. sy nose. And for prompt relief of these symptoms, ere's Novahistine® LP. These continuous-release tablets ve a vasoconstrictor-antihistamine formulation that gins working in minutes, then continues to provide ief for hours. Even when nasal congestion is due to eated allergic episodes, two Novahistine LP tablets, morning and evening, let most patients breathe freely all day and all night. Use with caution in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

Dow **THE DOW CHEMICAL COMPANY** Rx Pharmaceuticals Indianapolis

Clinical Extension of a pure Smooth Muscle Relaxant

TROCINATE®

Brand THIPHENAMIL HCl

400 mg./100 mg. S/C tablets

Trocinate relaxes all smooth muscles. Its direct action (musculotropic) does not involve the autonomic nervous system and it is not mydriatic. It is metabolized by the body and eliminated in the urine as harmless degradation products. Trocinate has a remarkable history of freedom from side-effects.

When a pure direct-acting smooth muscle relaxant is indicated, Trocinate is the drug of choice.

DIARRHEA (functional) . . . *the first 400 mg. tablet usually relieves the discomfort of diarrhea so promptly that it ceases to be a bother.*

DIVERTICULITIS—MUCOUS COLITIS . . . *the accompanying discomforts can be relieved by this direct smooth muscle relaxant.*

BLADDER SPASM . . . *relaxation is immediate. One or two tablets condition the bladder for cystoscopy in one hour.*

SPASTIC URETER . . . *the specific relaxing effect of Trocinate on the spastic ureter has been proven by animal studies and affirmed clinically. (J. Urol. 73:487-93)*

PRESCRIBING INFORMATION

WARNING: Do not give in advanced kidney or liver disease. PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. DOSAGE: 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determine when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a restful*

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Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CLINICAL CONVENTION
Date Nov. 29-Dec. 2, 1970
Place Boston, Mass.

INDIANA ROENTGEN SOCIETY
Date March 14, 1971
Place Holiday Inn East, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 12-15, 1970
Place South Bend

INDIANA ACADEMY OF GENERAL PRACTICE
Date April 20-22, 1971
Place Indianapolis Hilton

INDIANA PSYCHIATRIC SOCIETY
Date Second Wednesday of September, November, January, February, March and April
Place For time and place, inquire Wesley A. Kissel, M.D., 1815 N. Capitol Ave., Indianapolis 46202

INDIANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS
Date May 12-13, 1971
Place Indianapolis Stouffer Inn

INDIANA PUBLIC HEALTH ASSOCIATION
Date April 20-22, 1971
Place Indianapolis Stouffer Inn

THE INDIANA SOCIETY OF INTERNAL MEDICINE
Date October 14-15, 1970
Place South Bend

INDIANA STATE ASSOCIATION OF MEDICAL ASSISTANTS
Date April 23-25, 1971
Place LaSalle Motor Inn, South Bend

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY
Date Oct. 21, 1970
Place Atkinson Hotel, Indianapolis

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

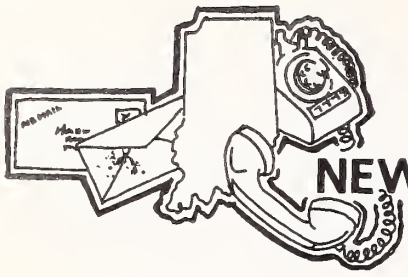
INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 4-6, 1971
Place French Lick Sheraton, French Lick

INDIANA ASSOCIATION OF PATHOLOGISTS
Date December 5, 1970
Place Indianapolis Motor Speedway Motel, Indianapolis

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NEWS NOTES

State of Indiana Awarded $67,421 for Drug Education Training

The state of Indiana has been awarded $67,421 in Federal funds for the training of Hoosier educators, students, and community leaders in the subject of drug education, Congressman Earl F. Landgrebe (R., Ind.) has announced.

Under this grant, the amount of which was based on the state's population of children ages five through 17, teams of teachers, counselors, school administrators, students and community leaders will be sent to four National Training Centers in Drug Education this summer.

The four centers are located at San Francisco State College, University of Texas at San Antonio, University of Wisconsin and Adelphi University. A total of $3 million in training grants has been made nationwide for this program.

Beginning in September, these trainees will have the capability to conduct intensive training for local school district teams throughout the state.

The Department of Health, Education and Welfare, which made the grant, estimates that approximately 150,000 local educators and 75,000 students at the local team level can be trained during the 1970-71 school year.

Dr. Jack Hickman to Take New Post in Florida

Dr. Jack W. Hickman, assistant dean for student affairs at Indiana University School of Medicine, has been appointed associate dean for student affairs at the new University of South Florida College of Medicine at Tampa, Fla.

A former director of medical education at Marion County General Hospital, Dr. Hickman was graduated from I.U. Medical School and studied internal medicine at Lahey Clinic at Boston, Mass., and Marion County General Hospital.

A member of *The Journal* Edi orial Board, Dr. Hickman was also a member of the ISMA Commission on Legislation.

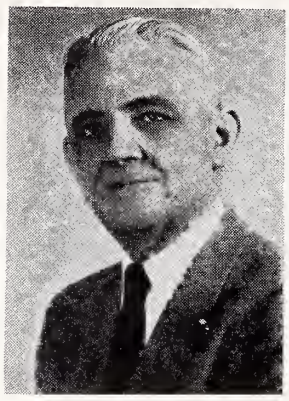
He is a diplomate of the American Board of Internal Medicine, a fellow of the American College of Physicians, and a member of the Association of American Medical Colleges.

Dr. Shumacker Named

Dr. Harris B. Shumacker Jr., one of the nation's outstanding surgeons, teachers, and researchers, who has been on the faculty of the Indiana University School of Medicine for 22 years, has been named Distinguished Professor of Surgery by the I.U. Board of Trustees, one of the highest academic titles available at the school.

Dr. Shumacker headed the school of medicine's Department of Surgery from 1948 until 1968, when he voluntarily retired from that post to devote more time to his patients and to teaching and research.

Dr. Owsley Named Chairman of AMA Council on Medical Service



Dr. Guy A. Owsley, Hartford City, eye, ear, nose, and throa specialist, has been named chairma of the Council on Medical Servic of the American Medical Associatio

The Council, along with its com mittees, comprise a most importan part of the organizational structur of the association.

Dr. Owsley, graduated from th I.U. School of Medicine in 1928 is a Life Fellow of the America Academy of Ophthalmology an Otorhinolaryngology. He is a mem ber and past president of the Delaware-Blackford County Medical Society; a past president of ISMA and has been a member of many ISMA commissions and committees.

Receive Honorary Degrees

Dr. James O. Ritchey, Indianapolis, Distinguished Professor Emeritus of Medicine at the I.U. School of Medicine, was awarded an honorary degree recently at the dedication of the new University Hospital at the Indianapolis medical center.

Dr. Eli S. Jones, Hammond, received the Distinguished Alumni Service Award at the same ceremonies.

Promotions, Appointments at I.U. School of Medicine

A promotion for an assistant dean and appointments for 11 new faculty members have been announced by Dr. Glenn W Irwin Jr., dean of the Indiana University School of Medicine.

The promotion from assistant dean of medicine to associate dean of medicine was given by the I.U. Board of Trustees to **Dr. Steven C. Beering,** who is responsible for the school's programs in continuing education for practicing physicians and for planning statewide programs in medical education.

The new members of the state medical faculty are:

Dr. Dean Paul Bonderman, assistant professor of clinical pathology. Dr. Bonderman, who holds a doctor of philosophy degree from the University of Iowa, has been senior chemist and assistant to the project director of the Iowa Community Pesticides Study at the University of Iowa.

Dr. Betty C. Corya, part-time assistant professor of medicine. Dr. Corya, a graduate of the I.U. School of Medicine, was medical director of Goodwill Industries in Indianapolis from 1964 to 1969.

Dr. Jerry A. Royer, assistant professor of postgraduate medicine and assistant to the dean of medicine. Dr. Royer, a graduate of the I.U. School of Medicine, recently completed his internship in Fort Wayne.

Dr. Charles R. Kelley, assistant professor of medicine. Dr. Kelley, a graduate of Jefferson Medical College in St. Louis, has been studying on a fellowship in internal medicine at the medical center of Indiana University-Purdue University at Indianapolis.

Dr. Kenneth J. Fawcett, assistant professor of medical technology. Dr. Fawcett, a graduate of the University of Michigan Medical School, has been a pathologist at the South Bend Medical Foundation.

Dr. David L. Kitzes, assistant professor of medicine. Dr. Kitzes, a graduate of the State University of New York Downstate Medical School, has been a fellow in cardiology at the

National Heart Institute.

Dr. Guy Paul DeRosa, assistant professor of orthopedic surgery. Dr. DeRosa, a graduate of the University of Notre Dame and the I.U. School of Medicine, has been senior resident in orthopedic surgery at the IU-PUI Medical Center.

Dr. Robert C. Martz, assistant professor of toxicology. Dr. Martz, a graduate of Wabash College and the I. U. medical school who is completing work toward a doctor of philosophy degree at I.U., has completed his internship at the Indiana University Hospitals.

Dr. Edwin T. Harper, assistant professor of biochemistry. Dr. Harper, a graduate of the University of Minnesota, has been assistant professor of chemistry at Clarkson College, New York.

Dr. Charles P. Morrow, assistant professor of obstetrics and gynecology. Dr. Morrow, a graduate of Loyola University, has been a senior fellow in oncology at the University of Texas.

Dr. Shirley Siew, associate professor of pathology. Dr. Siew, a graduate of the University of Witwatersrand, South Africa, has been senior lecturer in pathology and microbiology at Witwatersrand.

Goes to England

Dr. Joseph Bader, senior physician in clinical research for Eli Lilly, will serve as medical director for Eli Lilly, Ltd., of Basingstoke, England for one year while Dr. W. Ian H. Shedden, the present medical director at Basingstoke will come to Indianapolis to assume Dr. Bader's responsibilities.

Dr. Shedden has been clinical assistant at the Royal Edinburgh Hospital, house physician at the Royal Infirmary in Edinburgh, and was on the faculty of the University of Sheffield.

Dr. Martz Appointed

Dr. Carl D. Martz, Indianapolis, has been reappointed to a second three-year term on the American College of Surgeons Committee on Trauma.

Topics for Caleb Fiske Fund Essay Competition Announced

The Trustees of the Caleb Fiske Fund of the Rhode Island Medical Society, the oldest medical prize essay competition in America, announce two subjects for the 1970 essay contest:

"The Crisis with Hallucinogenic Drugs—Possible Solutions"

and

"Human Cell Cultures in the Diagnosis of Disease"

A cash prize of $500 is offered for the best dissertation on either subject. Essays must be submitted by December 15, 1970, and must be typewritten, double-spaced, and not in excess of 10,000 words.

For additional information write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis St., Providence, Rhode Island 02903.

New Rehabilitation Camp

Dr. Floyd B. Coleman, Waterloo, and the Rev. Julius Black, with the help of many others, are maintaining a camp on Ball Lake, near Waterloo and Hamilton, Indiana, for the rehabilitation of teen-agers who are the victims of drugs. A tax exempt entity, "New Life, Inc.," has been formed to support the camp and its activities. Public spirited citizens of Auburn are assisting.

Dr. Zahrt is Elected

Dr. Frank H. Zahrt, LaPorte, has been re-elected to active membership in the American Academy of General Practice.

Captain John R. Trittschuh Named Flight Surgeon of Year

Captain John R. Trittschuh is Air Force Flight Surgeon of the Year. He was 1969 Flight Surgeon of the Year for the Military Airlift Command.



Dr. Trittschuh, flight surgeon at Headquarters, Aerospace Cartographic and Geodetic Service, Forbes Air Force Base, Kan., was presented the Malcolm C. Grow Award during the 41st annual scientific meeting of the Aerospace Medical Association in St. Louis.

A native of Muncie, Dr. Trittschuh received his premedical training at Indiana University, Bloomington, and his M.D. degree from the I.U. School of Medicine.

Dr. Huffman Honored

Dr. V. Park Huffman, South Whitley, has been named recipient of the Citizen of the Year Award presented by the South Whitley Chamber of Commerce.

Geneva University Surgical Award Given to Non-Surgeon

The University of Geneva has given its major award in surgery to a non-surgeon, Leon Hirsch of New York City, in recognition of his improvement and adaptation of a stapling machine to use in intestinal surgery and for other surgical uses. This is the first time this award has been given for surgical instrumentation.

Dr. Crockett Speaks

Dr. Wayne A. Crockett, Terre Haute, spoke recently at the 10th anniversary dinner-meeting of the Vigo County Association of National Health Agencies. Dr. Crockett, president of the Terre Haute Medical Educational Foundation, gave a short history of the foundation.

Dr. Garceau Honored

Dr. George J. Garceau, chief of orthopedics at St. Vincent's Hospital, Indianapolis, was honored recently at a staff banquet. He was presented with a plaque commemorating his 25 years of service to the hospital. A library at the new St. Vincent's Hospital to be constructed will also be named for Dr. Garceau.

Physician Moderates

Dr. H. Jerome Reitman, Evansville, moderated a seminar on "Emotional Aspects of Problems Encountered in Family Practice" recently at Deaconess Hospital there. Lecturing physicians of the I.U. School of Medicine staff, **Dr. Hanus J. Grosz,** of the department of psychiatry and **Dr. Joseph F. Thompson,** of the department of obstetrics and gynecology, highlighted the program.

Operating Room Technicians Elect New State Officers

The Indiana Association of Operating Room Technicians announces the election of Iris Sarvich as president. Larry Lloyd will be vice-president; Norma Singo secretary; Opal Farmer treasurer and Dorothy Thomas corresponding secretary.

Jack Suchocki, Jerry Parks, and Lester Coates were chosen as

Continued

Continued

advisors to the Board of Directors. Iris Sarvich served as delegate to the national convention and Opal Farmer was alternate delegate. The national organization met in Fort Worth, Texas in July.

Dr. Martz Honored

Dr. Carl D. Martz, Indianapolis, has been named recipient of the Service to Mankind Award of the Sertoma Club of North Indianapolis. Dr. Martz has been instrumental in the promotion and development of an Indiana chapter of the National Hemophilia Foundation, has reorganized the orthopedic clinic at General Hospital and regularly spends one day a week at the clinic helping train new internists in the problems of the handicapped. Dr. Martz was selected for his "untiring devotion to children and his community beyond the usual call of duty." As the recipient of the district award, Dr. Martz becomes eligible for the international award to be made at a later date.

Dr. Erhart Speaks

Dr. H. G. Erhart, Huntingburg, recently appeared on a program at St. Joseph's Hospital there to which Jasper and Huntingburg volunteer firemen and ambulance drivers were invited. A film was shown, Dr. Erhart conducted a question and answer period and the firemen and ambulance drivers had a practice period on mouth-to-mouth resuscitation and external heart massage.

Indiana Student Wins AMA Award

James Gaither of Evansville is the recipient of an Award of Merit from the American Medical Association.

He was cited for his exhibit "Neural and Chemical Tracings of Uterine Contractions During Parturition" during ceremonies at the 21st International Science Fair in Baltimore.

He was chosen from more than 400 finalists at the Fair by a panel of physician-judges headed by Charles D. Bussey, M.D., chairman of AMA's Council on Scientific Assembly.



DR. and Mrs. Otis R. Bowen are pictured while in attendance at the annual session of the Medical Association of the State of Alabama in May. Dr. Bowen was featured at a well-attended Orientation Program, and participated, with Gov. Albert Brewer of Alabama, in the ALAPAC luncheon.

Dr. Furman Named

Robert H. Furman, M.D., will be the executive director of clinical research for Eli Lilly and Company. Dr. Furman was former the associate director of the Oklahoma Medical Research Foundation. He is director of the American Heart Association and a member of the board of editors for the *Journal of Chronic Disease*

Instructing Physician

Dr. William A. Koontz, Gas City, was instructing physician for courses in cardiopulmonary resuscitation for staff members and students at Indiana Northern University recently.

Addresses Group

Dr. Jefferson Klepfer, superintendent of the Richmond State Hospital, addressed members of the Monday Graduates recently at the First Baptist Church in Marion. The Monday Graduates are a group of former patients at state mental institutions.

Dr. Solymos Leads Workshop

Dr. Maria Solymos, Huntington, provided professional leadership recently for a workshop on mental health in that city. Elementary, kindergarten and special education teachers in Huntington County schools attended the workshop in Crestview Junior High School. The purpose was to help teachers recognize symptoms of emotional illness.

Babysitting Class

Dr. Helen Czenkusch, Indianapolis, conducted a class recently in babysitting for teen-agers at the Speedway Fire Department. The classes were jointly sponsored by the fire department and the Speedway Jaycees.

Eaton Laboratories Offers Parkinsonism Treatment Film

"The Treatment of Parkinsonism with Levodopa" is the title of a medical film which is distributed by Eaton Laboratories.

It is in color and sound, runs for 14 minutes, and can be obtained for showing to physicians by writing to Eaton Medical Film Library, Norwich, New York 13815, or by contacting a Eaton sales representative.

On Panel

A panel discussion on "Your Children's Health" highlighted a recent meeting of the Immanuel Lutheran Parent Teacher League at Seymour. Participating in the panel discussion were **Dr. Kenneth Bobb,** a dentist and an optometrist.

Dr. Somerville Speaks

Dr. J. W. Somerville, Clinton, explained the expansion of services of the Vermillion County Health Department to a recent meeting of the Clinton Optimist Club. Dr. Somerville is county health officer.

Named Chairman

Dr. Charles Griffin, Valparaiso, has been named chairman of the medical advisory committee of the Visiting Nurse Association of Porter County.

Heart Seminar

Dr. Thomas A. Elliott, a founder of the Elkhart Clinic, spoke on "The Heart, Its Diseases and Treatment" at an Elkhart General Hospital-sponsored public seminar recently at Elkhart High School.

New Medical Film Now Available to Members of ISMA

A new medical film "The Long-Range Problems of the Postmenopausal Woman" may be obtained from Ayerst Laboratories for showing to medical groups. It is in color and sound; running time is 43 minutes.

The clinical discussion is by Drs. Allan C. Barnes, Herman I. Kantor, and Gilbert S. Gordon. Write Dr. John B. Jewell, Ayerst Laboratories, 685 Third Ave., New York City 10017.

Heads Diabetes Group

Dr. Anthony S. Ridolfo, Indianapolis, is the new president of the Clinical Society of the Indianapolis Diabetic Association. Other officers include: **Drs. William F. Bastnagel, vice-president; James E. Ashmore, second vice-president; David L. Challoner, secretary and M. R. Shafer, treasurer.**

Speaks to Group

Dr. A. S. Williams, Lake County coroner, spoke recently before the Geriatric Interest group of District 2 of the Indiana State Nurses Association in Valparaiso. He spoke on "Laboratory Work and the Geriatric Patient."

Cancer Talk

Dr. Carlos Cespedes, Griffith, directed a Cancer Education Program for high school girls recently in Hammond, sponsored by the St. John Junior Women's Club. The program consisted of two films, followed by a question and answer period.

Dr. Stolz Speaks

Dr. Thomas J. Stolz, West Lafayette, spoke on "The Effects of Cigarettes" at a recent meeting of the Bolivar Township Farm Bureau at Otterbein.

Schering and Plough Plan to Consolidate

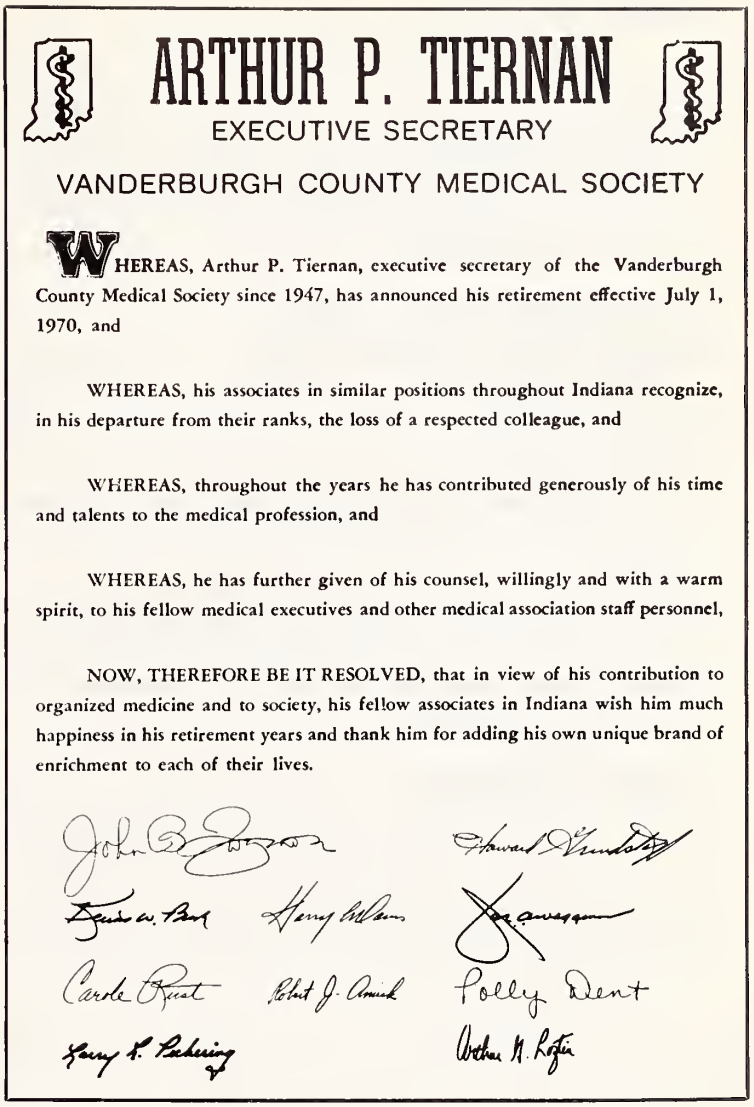
The Schering Corporation and Plough, Inc. will be consolidated soon. The new company, Schering-Plough Corporation, will operate each entity as a subsidiary. The product lines and activities of the two merging companies will remain the same.

New Department at I.U.

A new Department of Radiation Therapy has been created at the Indiana University School of Medicine. It will be originally situated and housed with the Department of Radiology, but will function as a separate department. **Dr. Ned B. Hornback** will be chairman. Later separate facilities for radiation therapy will be provided in the new University Hospital.

Chronic Bronchitis and Pulmonary Emphysema Film

A medical moving picture film "Chronic Bronchitis and Pulmonary Emphysema", is available on free short-term loan from the National Medical Audiovisual Center, Station K, Atlanta, Georgia 30324. It is in two parts, 29 minutes and 24 minutes, 16mm. color, sound. It covers the application of physical medicine and rehabilitation.



JAMES A. WAGGENER, executive secretary, ISMA, presented a special certificate to Arthur Tiernan, retiring executive secretary, Vanderburgh County Medical Society, at a dinner honoring Mr. Tiernan May 12 in Evansville. The certificate was designed and signed by ten of his staff counterparts in the ISMA and county medical societies.

Panel Moderator

"Drugs—Why Not?" was the title of a panel discussion for the public held recently at the Plymouth High School cafeteria. **Dr. J. Kent Guild, Plymouth,** served as panel moderator.

Speaker at Meeting

Dr. Eldred MacDonell, South Bend, reviewed several chapters of the book "How to Live With Diabetes" at a meeting of the Diabetes Association of St. Joseph County recently in South Bend.

Named President

Dr. George Buckner, Fort Wayne, has been elected president of the Fort Wayne Medical Society Foundation. **Dr. Robert Sullivan** was elected secretary-treasurer of the foundation, established in 1966 by the Fort Wayne Medical Society to make donations of funds or property to charitable and educational trusts and to encourage and develop scientific activities in medical science in Allen County.

Continued

NEWS NOTES

Continued

Speaks at Meeting

Dr. Thomas Hamilton, Columbia City, spoke on the value of chiropractic at a recent meeting of the Southern Indiana Association of Chiropractors. Dr. Hamilton is an M.D., a chiropractor and an osteopath.

Public Health Service Conducts National X-Ray Exposure Study

The Public Health Service is conducting a national survey to obtain information on population exposure to diagnostic and therapeutic X-radiation.

Previous studies were made in 1961 and in 1964. The '64 study was on a comprehensive scale and the present review will follow the same collection and analysis methods so that results may be compared.

A household survey, involving about 20,000 households and 65,000 persons will be the first phase. Questionnaires will obtain examination data from x-ray facilities identified by patients. Later an x-ray equipment survey will be done. All information obtained will be treated as confidential.

Awarded Fellowship

Daniel W. Kletzing, student at Indiana University School of Medicine, has been awarded a Smith, Kline & French Foreign Fellowship. This is the fellowship which enables the student to spend several weeks in a medical facility in one of the developing countries of the world. Kletzing will be stationed at the Burrows Memorial Hospital, Assam, India.



Speaker for Group

Dr. Charles E. Jackson, Bluffton, made a talk on prese day developments in medical research before members of t Bluffton Rotary Club recently.

Dr. Peyton Elected

Dr. Frank W. Peyton, Lafayette, has been re-elected to t Home Hospital board of directors.

Blood Bank Staff

Logansport physicians who served at a recent Red Cross Blo Bank collection at Memorial Home there were: **Drs. Jon Pavilionis, Camille Parker and Johnson Chu.**

Advises Actors

Dr. John Foster, Lafayette, acted as technical director f a Civic Theater presentation of "The Imaginary Invalid" Moliere at Lafayette recently. The play concerns hypochondria and the medical profession.

Two-Year Training Course For Occupational Therapy Assistants

A new two-year course for training of occupational thera assistants has been instituted by the Division of Allied Heal Sciences at Indiana University School of Medicine. The cour leads to an associate degree. The student may continue to a B. degree at a later date if desired. The new course is importa because of the critical shortage of trained assistants. Prospecti students may apply now. The course starts in September.

Dr. Moran Appointed

Dr. Thomas E. Moran, Indianapolis, has been appointed Governor Whitcomb to the State Board of Beauty Cultu Examiners.

Hospital Ceremony

Dr. Ben K. Harned, Jr., president of Baptist Hospita medical staff, spoke at ground breaking ceremonies held recent for the hospital's seven-story addition.

Smoking Dangers

The dangers of smoking were graphically presented to membe of the Girls Athletic Association recently at LaPorte Schoo seventh grade. Discussing the effects of smoking were: **Drs. S. Philbrook, Barbara Backer, J. C. Richter, Robert M. Kels and George Backer.**

Addresses Group

Dr. Floyd Coleman, Waterloo, addressed the second annu meeting of the Pigeon River Association of Steuben Coun recently at Angola.

Jaycees and AMA Promote Emergency Care Services

The American Medical Association and the U.S. Junior Cha ber of Commerce have launched a program to improve emergen services.

The lack of these services, in fact, inspired a copy writer identify this irony as "The incredible national problem adding insult to injury."

Hitting right between the eyes is this copy published by Employers Insurance of Wausau: "Injury is bad enough. But dying on the way to a hospital is the ultimate insult, isn't it?

"When you survive an accident, you'd also like to be allowed to survive the aid of your rescuers. But last year 20,000 people actually made it over the first hurdle. The second was too much for them. They became victims of double jeopardy.

"They died (and another 25,000 were permanently disabled) because they were lifted when they should have been left alone; because they weren't treated for shock, didn't get enough oxygen, or ran out of blood on the way to the hospital."

The "remedy" is now being advanced by a vigorous program conducted jointly by the AMA and the Jaycees.

wards Announced to I.U. nd Notre Dame for Research

The Hartford Foundation announces that an award of $20,974 as paid to Indiana University Foundation in Indianapolis 1969 for experimental and clinical studies of degeneration and generation in the central nervous system.

The University of Notre Dame received $63,891 during 1969 as rt of a large award of $169,051 for studies on resistance to rcinogenesis and tissue transplantation in germfree rodents.

oundation Makes Research, ledical Student Awards

The Pharmaceutical Manufacturers Association Foundation, since formation in 1965, has provided over $2.2 million for variety of workshops, conferences, research projects and educanal programs.

The mission of the Foundation is to improve the body of knowlge in clinical pharmacology and the therapeutic sciences. Thc undation is supported by over 100 of the leading pharmaceutical nufacturers and related groups.

Dr. Raymond M. Rice, Indianapolis, is vice president. **. Glenn W. Irwin, Jr., Indianapolis,** is a member of the culty Development Awards in Clinical Pharmacology Adory Committee. **Dr. Clyde G. Culbertson, Indianapolis,** is member of the Foundation Fellowship Awards in armacology-Morphology Advisory Committee.

ew Leaflet Tells "Truth bout Diet and Arthritis"

"The Truth About Diet and Arthritis," a leaflet published by e Arthritis Foundation, is for the purpose of protecting pats from quacks and food fanatics. The leaflet emphasizes that, th the exception of gout, no arthritic condition requires a spel diet.

Copies of the diet leaflet and other informative publications out arthritis are available without charge from the Arthritis undation, Box 2525, New York City 10001, or from its Indiana apter, 6285 N. College Ave., Indianapolis.

Indiana Medical Foundation

The Indiana Medical Foundation was organized to furnish support for the educational activities of the Indiana State Medical Association. These activities include programs for continuing education and the scientific publications of *The Journal.* Contributions made to the foundation are deductible by donors in accordance with the Internal Revenue Code. Bequests, legacies and gifts are deductible for federal estate and gift tax purposes. Memorial contributions made to the foundation will be formally recorded and acknowledgment will be sent to the family. Gifts, bequests, and memorial contributions may be mailed to the foundation at 3935 N. Meridian St., Indianapolis 46208.

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FUTURE MEETINGS, SEMINARS, COURSES

John B. Hickam Memorial Symposium Set for September

A John B. Hickam Memorial Symposium will be held at Emerson Hall of Indiana University Medical Center in Indianapolis on September 21 and 22.

It is one of the continuing education programs of the American College of Cardiology and is arranged by the I.U. School of Medicine, the University of Kentucky and The Krannert Institute of Cardiology. The registration fee of $50 includes the charge for two luncheons, one social hour and one dinner.

Apply for enrollment to Miss Mary Anne McInerny, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014.

American Board of Family Practice Announces Second Certification Exam

The American Board of Family Practice announces that it will give its *second* examination for certification in various centers throughout the United States.

The examination will be over a two-day period on February 27-28, 1971. Information regarding the examination and eligibility for the examination can be obtained by writing: Nicholas J. Pisacano, M.D., secretary-treasurer, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington 40506.

Deadline for receiving completed applications in the Board office is *November 1, 1970.*

International Symposuim on Drug Abuse Scheduled for November 9-13

An international symposium on drug abuse will be held at the Towsley Center for Continuing Medical Education in the University of Michigan Medical Center, November 9 to 13.

Although technical aspects will be handled, the objective of the symposium is to assist the practicing physician in coping with drug abuse in patient care. The problem will also be treated in relation to the community, schools, courts and social agencies.

For further information write to Donald C. Kraushaar, Department of Postgraduate Medicine, Ann Arbor, Michigan 48104.

AMA Congress on Occupational Health Will Meet in Los Angeles

The AMA Congress on Occupational Health will meet on September 30 and October 1 at the Century Plaza Hotel in Los Angeles. All interested physicians are invited. The program is acceptable for 12½ elective hours by the AAGP.

Society for Cryosurgery Meeting Set for March 1-5, 1971, in Florida

A Society for Cryosurgery meeting will be held March 1-5, 1971, at the Diplomat Hotel and County Club in Hollywood, Florida. All physicians interested in cryosurgical procedures and technics are invited to attend.

Cryosurgery in the following specialties will be discussed: general surgery, dermatology, gynecology, neurology, ophthalmology, otolaryngology, and urology.

For further information, write: Secretary, Society for Cryosurgery, 30 N. Michigan Ave., Chicago, Ill. 60602.

Arizona Heart Association's 14th Annual Cardiac Symposium

The Arizona Heart Association's 14th annual Cardiac Symposium will be offered at the Arizona Biltmore Hotel at Phoenix January 22-24, 1971.

Speakers on the program include Drs. Roman DeSanctis, Jose Perloff, Gilbert Blount and Rene Fabalero. For further particula write the Arizona Heart Association, 1720 E. McDowell Rd., Phoenix, Arizona 85006.

Gastroenterology Postgraduate Course Will Be October 29-31

A postgraduate course in gastroenterology will be conduct by the American College of Gastroenterology at the Statler Hilt Hotel in New York City on October 29, 30 and 31.

For further information and enrollment write the college at 2 Broadway, New York City 10007.

"Pulmonary Function Tests in Management of Chest Disease" Course

A postgraduate course on "Pulmonary Function Tests in M agement of Chest Disease" will be held September 17 through at the University of Kentucky Medical Center.

This course is planned for physicians and technicians who ha some responsibility for intensive care units and patients w chest disease. A $35 fee will be charged.

For further information contact Frank R. Lemon, M.D., Associ Dean, Continuing Education, College of Medicine, University Kentucky, Lexington, Kentucky 40506.

AMA Committee on Exercise and the Heart Schedules Symposium

A "Symposium on Exercise and the Heart" will be conduct by the AMA Committee on Exercise and Physical Fitness at t Sheraton-Cadillac Hotel, Detroit, on September 23.

The meeting is open to physicians and allied health personn Copies of the program may be obtained by writing Dr. Fred Hein, 535 N. Dearborn, Chicago 60610.

ISMA Members Invited to Military Surgeons Annual Meeting

The Association of Military Surgeons of the United States ho its 77th Annual Meeting at Washington, D.C., from Novemb 29 to December 2.

The scientific program has for its theme "Controversies in Me cine." The meeting is open to all physicians without registrati fee. Dr. Roger O. Egeberg will deliver the keynote address Monday morning.

uncheon Seminar on Cryosurgical rocedures in EENT Set for October 4

A luncheon seminar on cryosurgical procedures in EENT will e held on Sunday, October 4, at the Dunes Hotel, Las Vegas, mediately preceding the October 5 meeting of the American cademy of Ophthalmology and Otolaryngology.

Several papers will be read covering cryosurgery for the eye and r the ear, nose and throat. For full information write Secretary, ociety for Cryosurgery, 30 N. Michigan Ave., Chicago 60602.

ducational Course Announced n Clinical Electroencephalography

A continuation course on "Current Practice of Clinical Elec- oencephalography" will be held September 14-16 in Washington, . C. The course is designed to review the principal applications the EEG to clinical medical practice, and is sponsored by e American Electroencephalographic Society.

Inquiries about further details of the course or registration pro- dure should be addressed to Dr. Donald W. Klass, EEG Course irector, Mayo Clinic, Rochester, Minnesota 55901. ◄



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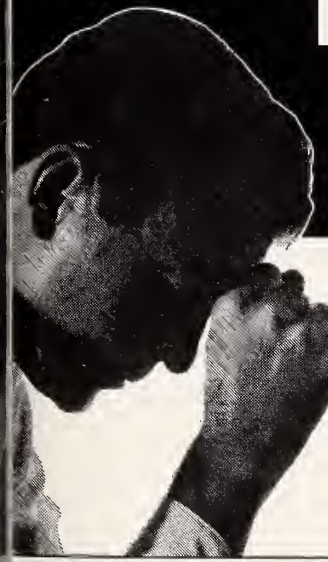
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County, District News

Second District

The Second District Medical Society met May 28 at Vincennes. President of the society will be the president of the Daviess-Martin County Medical Society for 1971. Dr. J. S. Brown, Carlisle, was re-elected secretary-treasurer and the 1971 meeting will be at Washington, Ind.

Fifth District

Dr. William G. Bannon, Terre Haute, has been elected president of the Fifth District Medical Society. Dr. James W. Christee, also of Terre Haute, was elected secretary; Dr. C. M. Schauwecker, Greencastle, was re-elected alternate trustee and Dr. Fred Dierdorf was re-elected Blue Shield Board member.

Seventh District

Newly-elected president of the Seventh District Medical Society is Dr. Ellery T. Drake, Martinsville. Dr. John Records, Franklin, was named president-elect and Dr. Donald Stephens, Indianapolis, was re-elected secretary-treasurer. The 1971 meeting of the group will be held at Martinsville.

Eighth District

The Eighth District Medical Society met June 3 at Muncie to elect the following officers: Drs. Eugene M. Gillum, Portland, president; Ralph E. Schenck, Portland, secretary-treasurer; Robert D. Williams, Anderson, alternate trustee and Donald Taylor, Muncie, Blue Shield Board member. The 1971 meeting will be June 2 at Portland.

Ninth District

The Ninth District Medical Society met June 11 at the Crawfordsville Country Club. New officers of the society will be those of the Hamilton County Medical Society. Dr. William M. Sholty, Lafayette, was elected trustee and Dr. Barton Bridge, Lafayette, was re-elected Blue Shield Board member.

Tenth District

The Tenth District Medical Society met June 3rd to hear a panel discussion on "Government Medicine." Participants on the panel included: Drs. V. J. Santare; Lowell H. Steen; Walter Repay and R. J. Bills.

Dearborn-Ohio

Newly-elected president of the Dearborn-Ohio County Medical Society is Dr. Francis A. Streck, Lawrenceburg. Dr. Gerald T. Bowen, Lawrenceburg, was named vice president and Dr. Leslie M. Baker, Aurora, was re-elected secretary-treasurer.

Fayette-Franklin

A representative from the John Hancock Life Insurance Company spoke on the "Relative Value Scale" at the June 9 meeting of the Fayette-Franklin County Medical Society.

Floyd

Dr. Gene S. Pierce has been elected president of the Floyd County Medical Society. Also elected were: Drs. Henry] Worley, vice president and Daniel I Cannon, secretary-treasurer. All of th officers are from New Albany.

Kosciusko

The Kosciusko County Medical Socie has re-elected Dr. William C. Parke to second term as president. Also re-elected posts in the society were Dr. Thomas] Keough, vice president and Dr. Cliffo Fiscus, secretary-treasurer.

Marshall

Dr. William Shriber, South Bend, spok on the various methods of contraceptio available today at the June 17 meeting the Marshall County Medical Society.

Montgomery

The Montgomery County Medical S ciety has re-elected Drs. James M. Kirtle as president and Dr. Wesley E. Shanno as secretary-treasurer for the 1970-71 yea Both are from Crawfordsville.

Tippecanoe

Dr. James West, a Chicago surgeo spoke on "Alcoholism is a Sickness" the June 9 meeting of the Tippecano County Medical Society.

Vanderburgh

Dr. John D. Wilson, Evansville, has bee elected president of the Vanderburg County Medical Society.

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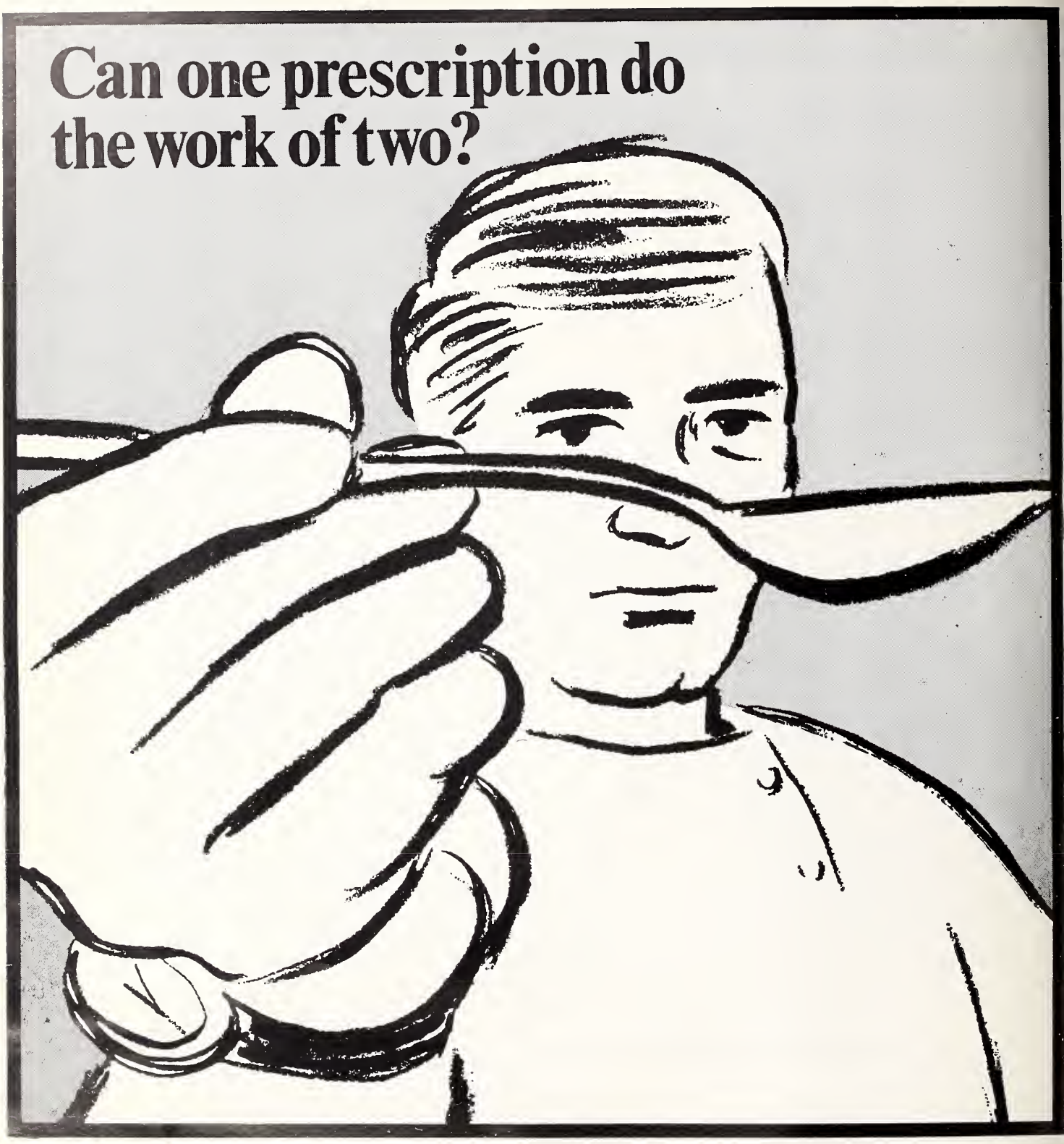
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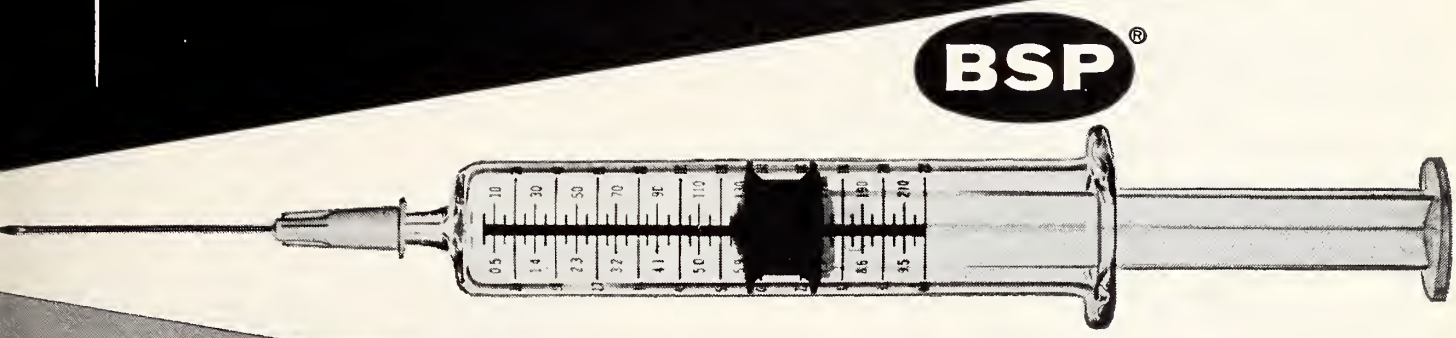
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Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

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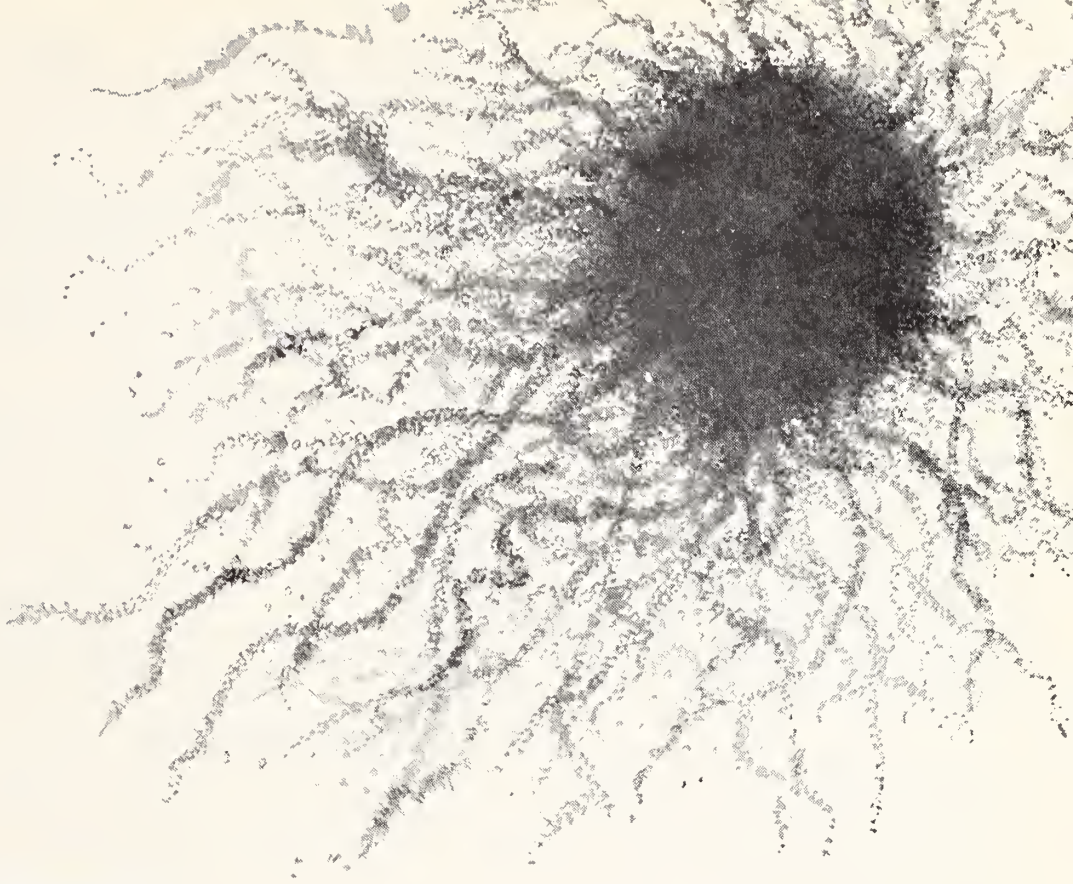
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Sandoz announces...

a new agent for the alcohol-dependent patient who wants to quit

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a program for the Indiana physician who wants to help





a major tranquilizer with specific advantages for the alcohol-dependent patient:

1. Alleviates tension, anxiety, and depression; may also ease prevalent neurotic symptoms in personality disorders.
2. No reported habituation or addiction.
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4. Has not caused hepatic dysfunction or interfered with functional recovery of impaired liver.
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6. Injectable form available for acute episodes.



program for early recognition and successful treatment:

Alcoholism in Indiana*

State Rank

total no. alcoholics	13th
na. per capita	20th
per capita cansumptian†	37th

Indiana Physicians' Report
(campared with U.S. average)

	%Ind.	%U.S.
see 5 or mare problem drinkers in 2-month period	38.4	37.1
half or more seen are wamen	38.8	37.4
treat, rather than refer	73.2	72.6
more community services needed	61.7	63.0

*based an preliminary data supplied by Center af Alcahal Studies, Rutgers Univ. †absolute alcahal

The Ins-and-Outs of Alcoholism: A series of recordings and other mailings, each concerned with a particular aspect of the alcohol problem. Recognized authorities in the field discuss the scope, recognition and treatment of alcohol-dependent patients. Also included will be **The Alcoholic Directory,** a nationwide survey of treatment centers.

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SERENTIL®
(mesoridazine)
new weapon in the fight against alcoholism

INDICATIONS: In clinicol studies, Serentil (mesoridazine) has been found useful in the following diseose states:

Alcahalism—Acute and Chranic: Serentil omeliorates anxiety, tension, depressian, nausea and vomiting in bath acute and chronic alcoholics without praducing hepatic dysfunction or hindering the functional recovery of the impaired liver.

Schizaphrenia: Serentil is effective in the treatmenr of schizaphrenio. It substantially reduces the severity of Emational Withdrawal, Conceptual Disarganizatian, Anxiety, Tension, Hallucinatory Behavior, Suspiciousness and Blunted Affect in schizophrenic patients. As with other phenothiazines, patients refractary ta previous medication may respond to Serentil.

Behaviaral Problems in Mental Deficiency and Chranic Brain Syndrame: The effect of Serentil was found to be excellent or good in the management of hyperactivity ond uncooperativeness associated with Mental Deficiency and Chronic Brain Syndrome.

Psychaneuratic Manifestatians: Serentil reduces the symptams af anxiety and tension, prevalent symptams often ossociated with neurotic components af mony disorders, and benefits persanality disorders in general.

CONTRAINDICATIONS: As with other phenathiozines Serentil (mesaridazine) is cantraindicated in severe central nervous system depression or comatase states fram any cause. Serentil is contraindicated in individuals who have previously shown hypersensitivity to the drug.

WARNINGS: Where patients are participating in activities requiring complete mental olertness (e.g., driving), it is advisoble ta administer the phenothiazines coutiously ond to increose the dosoge gradually.

Usage in pregnancy: The sofety of this drug in pregnancy has not been estoblished; hence, it should be given only when the onticipoted benefits to be derived from treatment exceed the possible risks to mother ond fetus.

Usage in children: The use of Serentil in children under 12 yeors of age is not recommended, becouse sofe conditions for its use hove not been estoblished.

Attention should be paid to the fact thot phenothiozines ore capoble of potentioting centrol nervous system depressonts (e.g., anesthetics, opiotes, olcohol, etc.) as well as otropine ond phosphorus insecticides.

PRECAUTIONS: While ocular chonges hove not to date been reloted to Serentil, one should be owore thot such changes have been seen with other drugs of this class.

Because of possible hypotensive effects, reserve parenteral odministration for bedfast patients or for acute ombulatory coses, ond keep potient lying down for at least ½ hour after injection.

Leukopenia and/or ogranulocytosis have been ottributed to phenothiozine therapy. A single cose of transient granulocytopenia hos been ossocioted with Serentil (mesoridozine).

ADVERSE REACTIONS: Drowsiness ond hypotension were the most prevalent side effects encountered. Side effects tended to reach their maximum level of severity early with the exception of o few (rigidity and motoric effects) which occurred later in therapy.

With the exceptions of tremor and rigidity, adverse reactions were generally found amang those patients who received relatively high doses eorly in treatment. Clinical dato showed no tendency for the investigators to terminate treatment because af side effects.

Serentil has demonstroted o remarkably low incidence of adverse reoctions when compared with ather phenothiazine compounds.

Central Nervaus System: Drowsiness, Porkinson's syndrame, dizziness, weakness, tremor, restlessness, ataxia, dystanio, rigidity, slurring, akathisio, motoric reactions (opisthotonos) have been reported.

Autanamic Nervaus System: Dry mouth, nausea and vomiting, fainting, stuffy nose, phatophabia, canstipotion and blurred vision hove occurred in some instances.

Endacrine System: Inhibition of ejaculation and lactation have been noted rarely.

Skin: Itching, rosh, hypertrophic popilloe of the tongue and angioneurotic edemo hove been reported.

Cardiavascular System: Hypotension and tochycardio hove been reported. EKG chonges hove occurred in some instonces (see Phenothiozine Derivotives: Cordiovascular Effects).

Phenothiazine Derivatives: It should be noted thot efficocy, indications ond untoward effects hove voried with the different phenothiozines. The physicion should be aware thot the following hove occurred with one or more phenothiazines and should be considered whenever one of these drugs is used:

Autanamic Reactians: Miosis, obstipation, onorexio, porolytic ileus.

Cutaneaus Reactians: Erythema, exfoliative dermotitis, contoct dermotitis.

Blaad Dyscrasias: Agranulocytosis, leukopenia, eosinophilia, thrombocytopenio, onemio, aplastic onemio, pancytopenio.

Allergic Reactions: Fever, loryngeol edema, angioneurotic edemo, osthmo.

Hepatataxicity: Jaundice, biliory stasis.

Cardiovascular Effects: Changes in the terminal portion of the electrocordiogram, including prolongation of the Q-T intervol, lowering ond inversion of the T-wave and oppeoronce of o wove tentatively identified as o bifid T or o U wave hove been observed in some patients receiving the phenothiazine tronquilizers, including Serentil (mesoridozine). To date, these appeor to be due to altered repolarization and not reloted to myocardiol damoge. They appeor to be reversible. There is no evidence at present that these chang are in ony woy precursors of ony significant turbance of cardiac rhythm.

Hypotension, rarely resulting in cardiac arr hos been noted.

Extrapyramidal Symptams: Akathisia, agitat motor restlessness, dystonic reactians, trisr torticollis, opisthotonos, oculogyric crises, tren muscular rigidity, akinesia—some of which rare occasions have persisted for several man or years especiolly in patients of advanced a with broin domoge.

Endacrine Disturbances: Menstrual irregularit altered libido, gynecomostia, weight gain. Fa positive pregnancy tests have been reported.

Urinary Disturbances: Retention, incontinence.

Others: Hyperpyrexia. Behavioral effects sugg tive of a paradoxicol reactian have been repart These include excitement, bizorre dreams, agg vation of psychoses and toxic confusional sta More recently, a peculiar skin-eye syndrame h been recognized as a side effect follawing la term treatment with phenothiozines. This reacti is marked by progressive pigmentation af are of the skin or conjunctivo and/or accompanied discaloration of the exposed sclera and carn Opacities of the anterior lens ond cornea scribed as irregular or stellate in shape ha also been reported.

DOSAGE AND ADMINISTRATION: Oral: The d age af Serentil (mesoridazine), as in mast me cations, should be adjusted ta the needs af t individual. The lowest effective dosoge shau always be used. When maximum respanse achieved, dosoge moy be reduced groduolly a maintenance level.

Alcahalism: For most potients the usual starti dose is 25 mg. b.i.d. The usuol optimum to daily dose range is 50-200 mg. per doy.

Schizophrenia: For most patients, regordless severity, o storting dose of 50 mg. t.i.d. is rec mended. The usuol optimum totol daily dose ran is 100-400 mg. per doy.

Behaviaral Problems in Mental Deficiency a Chranic Brain Syndrome: For most patients a st ing dose of 25 mg. t.i.d. is recommended. T usual optimum total daily dose range is 75-300 r per doy.

Psychaneurotic Manifestatians: For most patients t usual storting dose is 10 mg. t.i.d. The usual o mum tatol doily dose range is 30-150 mg. per d

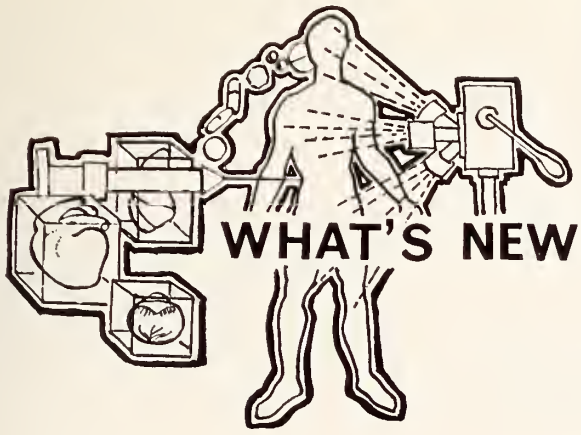
Injectable Form: In those situations in which intramusculor form of medication is indicat Serentil (mesoridazine) Injectable is avoiloble. F most potients o storting dose of 25 mg. is rec mended. The dose may be repeated in 30 ta minutes, if necessary. The usual optimum total da dose ronge is 25-200 mg. per doy.

HOW SUPPLIED: Tablets: 10 mg., 25 mg., 50 m ond 100 mg. mesoridozine (os the besylate). B tles of 100.

Ampuls: 1 cc. [25 mg. mesoridazine (os the bes ote)]. Inactive ingredients—Disodium Edeta U.S.P., 0.5 mg.; Sodium Chloride, U.S.P., 7.2 mg Carbon Dioxide Gas (Bone Dry), q.s.; Water f Injection, U.S.P., q.s. to 1 cc. Boxes of 20 and 1

SER70-101

Sandoz Pharmaceuticals, Honover, N.J.



WHAT'S NEW?

Medical Personnel Pool is opening a branch office in Indianapolis. The location is 1229 Circle Tower Building. The Pool specializes in providing private-duty nursing care in the home, nursing home and hospital. It will also provide temporary medical and technician help to doctors on an emergency basis. This includes registered nurses, licensed practical nurses, practical nurses, nurses aides, live-ins, companies and male attendants to hospitals, nursing homes and private individuals.

* * *

Fairfield Surgical and Medical-Electronics announces a unique cardiac warning unit that monitors both ECG and peripheral pulse. It is designed for use in intensive care, cardiac care, surgery and recovery rooms. It combines a cardioscope, a pulse tachometer and high-low alarms. Both audible and visual alarms are provided. Color-coded lamps indicate the nature of the alarm.

* * *

That set screw control on a blood pressure bulb has been improved on by Taylor Instrument. Their new Tycos Micro Valve can be manipulated with the finger and thumb of the hand (either right or left) which pumps the bulb. To the right closes the port, to the left opens it and the release of air can be made slowly or rapidly.

* * *

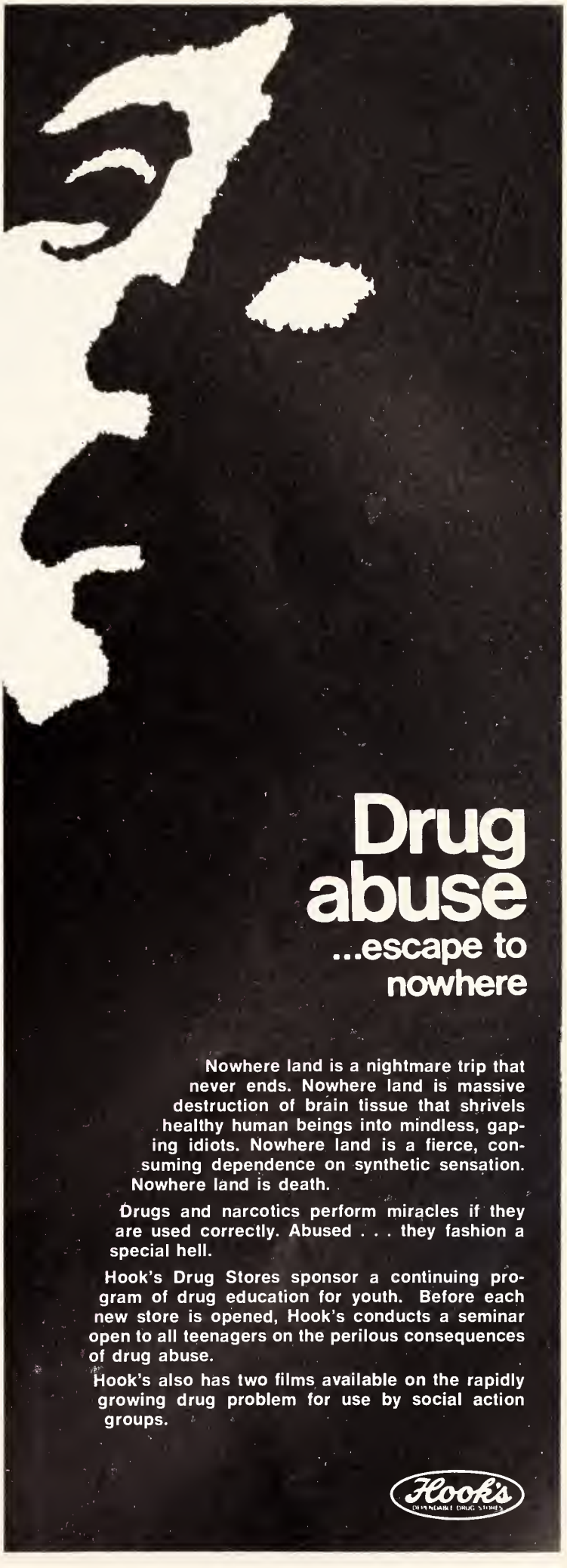
Mead Johnson is introducing Mucomyst-10, a 10% acetylcysteine, in order to provide convenient mucolytic therapy for patients using nebulizing units in their homes. The original Mucomyst was a 20% solution and has been used primarily in hospitals.

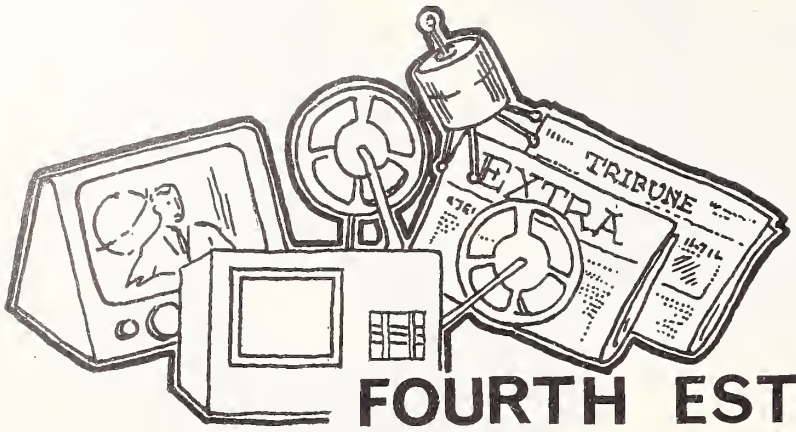
* * *

New Kenwood sterile urethral catheter trays which are totally disposable are now available from Will Ross. The tray is complete with sterile gloves, pre-moistened swabs, a fenestrated drape, plastic catheter and specimen container.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.





FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

The AMA Looks at Abortion

Although the element of discord probably was underplayed in most of the press, the American Medical Association last week approved a new official AMA policy on abortion which generally is interpreted as a liberalization of the organization's past policy.

In fact, the policy is so carefully worded and so diverse in its implications that it might be seen more as a statement of non-policy — with a few limitations!

First of all, the new policy statement recognizes abortion as a medical procedure. It permits a doctor to abort a pregnancy, in the words of Dr. Wendell G. Scott, chairman of the committee which recommended the new position, "for any reason that he determines is in the best medical interest of a patient."

Dr. Scott indicates that the term, "medical interest," is broad enough to cover the welfare of the pregnant woman, including such factors as whether or not her family has enough money to support an additional child, and whether or not the job of taking care of another child might be too big for her.

However, the resolution also introduces these limitations: the abortion is to be performed only in accordance with applicable state laws; a doctor is not required to perform an abortion against his own conscience or judgment; and the doctor would be required to consult with two other doctors before undertaking the operation.

The hot debate over the resolution found at least one opponent charging that the provision for consultation was a deliberate attempt to increase fees — with the increase amounting to a possible $200 or $300 million in the country. Other critics claimed (legitimately, it seemed to us) that the resolution subjected medical ethics to the control of state laws.

Offhand, the policy comes extremely close to providing "abortion on demand," subject only to the inclinations of the attending doctor, state laws, and a medical determination of the patient's overall state of well-being extending far beyond the customary limits of medical responsibility and authority.

It is rather interesting that the new president-elect of the AMA, Dr. Wesley W. Hall, of Reno, Nev., considers the new policy too liberal — one he "couldn't live with . . . as a permanent policy."

Catholic physicicans generally opposed the resolution and there is some talk it might result in a general withdrawal of members of their religious faith from the AMA, which would constitute an unprecedented schism in that organization and vastly alter its authoritative role in the profession. According to reports made at the convention in Chicago, many non-Catholic doctors had threatened to quit the organization if it adopted a "liberal" abortion policy.

Whatever else may be said about the AMA's new stand on abortion, we cannot see it as a very courageous policy, hedged, as it is, by limitations of questionable reason or relationship. Neither, for that matter, is it a very clear policy.—*Fort Wayne News-Sentinel*, June 30, 1970.

For More Doctors, Too

The "medicredit" plan backed before Congress by the American Medical Association and the largely black National Medical Association as a replacement for Medicaid makes considerable sense, but it needs to be coupled with something else.

What needs to be linked with the "medicredit" program — the first backed jointly by the two doctor groups — is a plan for the creation through stepped-up education of more doctors.

What the groups are asking Congress to do — with Nixon administration support — is to adopt a system of compulsory medical insurance. Under their plan the federal government would set up compulsory medical insurance with the proviso that premium payments for poorer families would be paid in whole or in part by the federal government, depending on the level of substandard income.

With "Medicaid" costs getting out of hand, the proposal appears highly reasonable. It would set up a means of paying in advance for services which we believe are in the public interest.

However, one reason for the dif-

ficulty of carrying out the present Medicaid program would remain. That is that there just are not enough doctors to provide all the services which the public now believes necessary or advisable.

The answer is to create more doctors. Certainly standards of professional skill should not be reduced. However, it would be necessary to increase both number and the size of medical schools. That is a responsibility of both the state and federal governments.

We hope both medical groups would back that kind of approach as well as the health insurance program they now are jointly supporting.—*Gary Post-Tribune*, June 19, 1970.

Solutions for Doctor Shortage

The shortage of doctors is getting some fresh attention. Gov. Edgar D. Whitcomb predicted at Lafayette this week that an unusual plan of medical education in Indiana will end the state's physician shortage and serve as a model for meeting the nation's medical care needs.

The 1971 General Assembly will be asked to approve the plan, which calls for the establishment of seven regional centers at which students can take up to two years of their training.

Whitcomb said he hoped the centers could be established by September, 1971, and that within four years the state would be graduating 50% more physicians than it now does.

Under the plan, at least 100 freshmen would be added to the class of 227 which normally enters the I.U. School of Medicine every year. Students would take their first and fourth years at the regional centers, and their second and third-year work at Indianapolis.

Dr. Glenn W. Irwin Jr., dean of the I.U. medical school, said the plan would boost by 50% the number of physicians trained in the state. He said he believed that would meet the needs of the state.

I.U. will admit about 250 medical students at Indianapolis this fall out of a total of 1,200 applicants. Irwin said about 500 applications were from Indiana residents.

Noting the number of Indiana medical students who in the past have left the state to practice, Irwin said there is a direct correlation between where medical students intern and where they eventually practice.

He noted that in the last three years Indiana has increased by 103 its number of interns and residents. Irwin said he is concerned with getting more people into medical school, and that a side benefit would be the retention of greater numbers of doctors in Indiana.

Meanwhile, the American Medical Association, at its convention this week in Chicago, heard a proposal by its president, Dr. Walter C. Bornemeier, to solve the doctor shortage by getting doctors into practice six years from high school instead of 11 years.

The average physician now must complete four years of pre-medical school, four years of medical school, a one-year internship and a minimum two-year residency. In addition to abolishing the residency program and the internship, the medical school training program could be cut by two years, Dr. Bornemeier said.

The AMA policy-making house of delegates then approved a measure that would eliminate all internship programs by 1975. A pertinent question, it seems to us, would be why wait until 1975 to shorten the time when a doctor could begin practice? There may be good reasons, but terminating internships sooner than five years from now would seem in order.—*Kokomo Tribune*, June 27, 1970.

Call a Doctor, Somebody

For a nation which spends $60 billion a year on health, a nation of joggers and pill-takers, a nation of dieters and food faddists, the United States has done an incredibly inept job of training enough doctors, dentists and nurses to care for 205 million people.

Our medical manpower programs have been so sorely neglected that literally millions of Americans are receiving inadequate health care or no care at all.

The situation is so serious that Dr. Roger O. Egeberg, the Nixon administration's top medical man, soon will ask the President and Congress to spend an extra $150 million this fiscal year on the health professions —with much of the money going to financially distressed medical schools.

Indiana is embarking on a plan to expand medical education and to retain those trained. Federal aid could accelerate the program, including the Evansville aspects.

A report by Don Kirkman, Scripps-Howard science writer, in *The Evansville Press* yesterday shows an unmet need for 50,000 additional doctors, 10,000 dentists, 150,000 nurses and thousands of other health specialists of all kinds.

Meanwhile, despite these shortages, a committee of 100 prominent citizens has recommended a national health insurance plan (effective in 1973) that would put even more strain on our sagging health resources.

Not only are the present programs —like Medicare and Medicaid—running far ahead of cost estimates, but some family doctors are working 70 hours a week just to keep up with the increased demand for their services.

At least two points need to be made before we go galloping ahead with any new health care schemes:

—The nation is turning out only 9000 new doctors a year. It should be training twice that many. This means more federal aid for medical schools, and especially for students from poor and modest-income families who simply can't afford a medi-

Continued

cal education now.

—Too many doctors practice in the suburbs, where incomes are high and the living is pleasant. Why not offer medical scholarships in return for two years of service in the small towns and city slums?

There are other ways to approach the problem: Setting up inner-city (or rural) medical clinics, with doctors working there part-time; shortening a doctor's post-high school education to six years; using nurses and medical technicians to perform routine duties like inoculations and bandaging.

But none of this will happen unless the nation soon faces up to the fact that you can't call a doctor—or any other kind of medic—unless there's one to call.—*Evansville Press*, July 8, 1970.

Good Medical News

Gov. Edgar Whitcomb's endorsement of a plan to bring medical centers to our area and six other areas of the state is good news. Not surprising, but good.

It is much less than northwest Indiana needs, much less than this area tried to get—a medical school.

But it is a hopeful compromise full of possibilities and promise. The 1971 legislature should back it vigorously.

A committee headed by Acting Chancellor George Thoma of the Gary I.U. campus is looking for a director. Administration space has been offered by the I.U. campus here, further indication of the value the campus has for the area.

The hope is that up to 24 persons could be admitted in September, 1971, to begin the medical center program, with facilities in hospitals being used. The "Center" would not be one in the physical sense, but it would exist, nevertheless.

Setting up the seven centers is a compromise arrived at after the General Assembly failed to agree on the site for a second state medical school. Several areas, including ours, presented evidence and arguments, but legislators, for various reasons, couldn't agree where to set up the school.

That doesn't mean the idea of a second school is dead. The vigor with which the local center plan is attacked in the seven communities could help determine where a second school should be. The center in our area is a positive step and our legislators should get behind the plan eagerly. Then local leaders should see to it that the medical center here becomes the best of the seven.

Winning the center won't be the end, but the beginning.—*Gary Post-Tribune*, July 19, 1970.

Sky's the Limit . . .

Last week at Schererville, representatives of Lake, Porter, LaPorte, Jasper, Starke, Newton, and Pulaski counties heard an explanation of the plan to establish two-year medical education programs in northwestern Indiana and six other sections of the state to augment Indiana's only four-year medical school.

Indiana University's medical school is the largest in the nation. It has apparently reached the point of diminishing returns so far as increasing its enrollment is concerned. Under the plan, a student, after his four years of college, could, if accepted by the I.U. school of medicine, take his first and fourth years of medical school at one of the regional centers. In northwest Indiana, the regional director would be located at Indiana University northwest campus at Gary, and serving on the teaching staff would be area doctors and faculty members of the I.U. Northwest, Purdue Calumet campus, and St. Joseph's Calumet campus.

The Governor's Commission on Medical Education is optimistic that the 1971 legislature will "buy" the plan and hopes that there can be implementation of it by next September. Previous legislatures have bogged down over which section of the state should get a medical school, with the result that none of competing proposals passed. The commission hopes that the regional scheme, plus the previously-approved increase in internships available in Indiana, funded by the legislature, will help Indiana educate and retain a greater number of physicians.

We happened to discuss the plan recently with a former Rensselaer physician, Dr. Martin J. O'Neill, now of Valparaiso. While O'Neill has no particular quarrel with the regional plan, he thinks it would be a mistake not to continue planning now for an eventual second full medical center in the state. We also talked with Sen. Charles Kleinkort who thinks the regional plan is a good one.—*Rensselaer Republican*, July 21, 1970.

Pollution Control—Particulates and Sulphur Dioxide

The Indiana Air Pollution Control

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Your ulcer patients and others will appreciate it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.
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Board decides on Thursday how much particulates and how much sulphur dioxide will be allowed in central Indiana air—and how much of these pollutants may be emitted from power plant, factory, and heating plant smokestacks.

There has been little opposition to the Board's proposed rules on particulates—which may be defined as the pollution we can see. But Indiana coal producers and the electric utilities, which are their best customers, are vigorously opposing the sulphur dioxide proposals.

Sulphur dioxide, a gas released by the burning of coal and oil, combines with moisture to form sulphuric acid. It has been implicated as a major cause of deaths in several air-pollution disasters—in Belgium in 1930; at Donora, Pennsylvania, in 1948; in London in 1952.

Opponents of the standards argue that no system exists for reduction of sulphur dioxide emission. Yet, at least two firms are marketing such systems and guaranteeing results.

The Union Electric Company of St. Louis, now using one of these, says there is "no question that guaranteed removal efficiency can be obtained." And the Illinois Power Company proposes to install another, terming it an "investment in the future."

Power plants and major industries are the chief producers of particulates and sulphur dioxide. Effective reduction of pollutants from power plants is especially important because of the rapid increase in the demand for electric power. In Indiana and many other states, failure to control sulphur dioxide emission may well mean both power shortages and dwindling markets for Indiana coal.

Failure of state boards to take effective action also will mean—without doubt—that Congress will move, in a matter of months, to set up national controls.

We hope the Air Pollution Control Board confirms the standards it has proposed. Such action will help demonstrate what is so often claimed—that Indiana can handle its own problems. And it will help establish that we have the two essentials of our times—courage in dealing with the present and vision in protecting the future.—*WFBM Editorial.*

Job Well Done

The disclosure that Dr. Henry G. Nester plans to retire this fall serves as a reminder of the conscientious and able job he has done for the last 19 years as Marion County director of public health.

Dr. Nester has many accomplishments to his credit. There are no polio cases in the county and haven't been since 1963, due to a polio vaccination program among school children that was begun in 1954. The nation's first successful vaccination program for rubella (measles) was conducted here under his direction. He prepared the minimum housing code standard law in 1953 and decentralized public health nursing stations in 1960 so that nurses could save time going to their districts. He has conducted a persistent rabies prevention campaign.

Nester holds Ph.D., M.D., and M.A. degrees, and has a comprehensive medical and scientific background that has well-suited the job of public health director. The staff of 396 employees under his direction have long been aware that he never asks them to do anything he would not do himself. Marion County has been fortunate in having such a man in that important post. When he retires, it should be a satisfaction to him that the community health is better because of his work.—*The Indianapolis News,* August 3, 1970.

Did You See That TV Show About Your Doctor?

The other night, one of the networks ran a special about doctors.

It caused some talk.

The people who wrote it seemed to feel that government should take over medicine.

In one breath they said the big problem with medical care is that we're short 50,000 doctors and 200,000 nurses. And that's true.

Then they claimed more medical manpower won't help until we get a "plan." Until "our medical system is overhauled."

And then, after saying doctors wouldn't treat poor people, they said doctors found Medicaid "profitable." Well, Medicaid IS medical care for the poor. And they scolded that some doctors were making $25,000 a year on Medicaid, which is about what a good union craftsman now gets. (And out of it, the doctor pays his own office expense.)

The 280,000 practicing doctors of this country are doing more than all the TV networks combined to cure the doctor shortage. Nobody who puts in their hours thinks there isn't a problem.

And nobody who works that hard taking care of sick people can quite understand why a TV network should twist the truth to beat him up for it.

So we'll sponsor our own TV special in a couple of months, to offer you the facts.

We hope it finds you in good health, settled comfortably in front of your TV set.

(This article sponsored by Whitley Co. Medical Assn.)—*South Whitley Tribune.* ◄

Letters

to the editor

July 27, 1970

To the Editor:

The symposium on Dr. Link was most interesting, and your contribution was tops. While I never had the pleasure of meeting Dr. Link, I have heard much about him—but not as detailed as presented in the July *Journal*. I would say that you have done well to honor a top member of our profession who certainly deserves such attention.

In secondary comment, I must say that the Arch Booth editorial was very good—but it does not outweigh the many adverse positions that the Chamber has taken over the past 20 years. It strikes me to be akin to the few cases that the American Civil Liberties Union aids on the conservative side of its predominantly left-wing sponsorship.

Sincerely,
ARTHUR G. BLAZEY, M.D.
Washington, Ind.

July 22, 1970

To the Editor:

Recently we had occasion to read editorial comments in your journal concerning the role (or lack of role, as you saw it), of the "Clinical Pharmacist." While your statements concerning the knowledge of today's pharmacist are at least somewhat accurate (re pharmacology, dosage, side effects, drug-drug interactions, adverse reactions, etc.), you seem rather unwilling to recognize the benefits of patient-oriented application of these knowledges, and others which the pharmacist in progressive universities are currently receiving. We are taking this opportunity to inform you of situations in which we, and an ever-increasing number of our colleagues, find themselves, which may alter your current viewpoints.

First of all, we should comment on educational changes occurring in several schools of pharmacy (most notably the University of California and the University of Southern California). At these schools, curricula stress the importance of knowing drug therapies *as they relate to individual patients*, particularly clinical data which affects drug therapy for each patient. Students at these schools receive extensive training in outpatient and inpatient clinical areas. For example, in the University of California Comprehensive Care, Primary Care, and Pediatric Clinics, a senior medical and a senior pharmacy student are teamed together to provide health care delivery in a true health team situation. Both medical and pharmacy students follow all aspects of the patient, including medical and drug histories, physical examination, consultation and initiation of therapies as needed, and follow-up. Here we should note that pharmacy students have been particularly invaluable in performing drug histories and therapy consultations. In fact, many medical students have specifically requested that they be teamed with a pharmacy student so that they may provide improved patient care. It is also important to note that these therapy consultations are performed with both a medical student and a private physician who serves as a clinical consultant. This environment provides both the medical and pharmacy student with practical knowledges of drug therapy for future application. In addition to these outpatient functions, our students also participate in ward rounds (they do not merely observe); they give clinical pharmacology lectures to interns, residents, and medical staff twice a week on teaching rounds (this was initiated at the request of the medical staff and the topics are chosen by the medical staff); they take drug histories of inpatients, and perform consultative functions with all medical personnel on the floor.

This education has proven its applicability in the practice of pharmacy in this institution and in several private institutions in which our students and graduates have and are practicing. We currently provide clinical pharmacy services primarily on two floors of our inpatient facility (which includes the services of general surgery, neurosurgery, vascular surgery and transplants), and are in the process of expanding this service to two more floors. In addition, the on-duty pharmacist is an integral member of the hospital's cardiopulmonary resuscitation team. Our new outpatient facility will have pharmacists on each floor providing services to patients and medical staff. Medical personnel have been extremely enthusiastic about our services. In addition, we provide a Drug Information Analysis Service to the greater San Francisco Bay Area. Questions directed to this service relate to specific problems with specific patients and, therefore, answers cannot be "theoretical, academic, or experimental," but must be clinically significant.

Both of us have also had experience in a local community hospital, where the medical staff took an initial conservative and reluctant view concerning our clinical participation in patient care. However, it soon became clear to the medical staff that our clinical involvement was for the benefit of the patient and that our role was not "of an interloper without portfolio as a therapist or an encroacher upon the practice of medicine." In fact, recently the medical staff of that hospital has requested that a pharmacist accompany them on ward rounds to provide immediate therapeutic consultation prior to initiation of therapy.

In all of these instances, there is a definite delineation between the role of the physician and pharmacist and neither has encroached upon the ex-

pertise of the other. Instead, we have found a mutual compatability and are together working hand in hand to provide improved patient care.

Respectfully,

ROBERT A. KERR, PHARM. D.
Resident in Hospital Pharmacy
University of California,
San Francisco
ANTHONY S. MANOGUERRA
Intern in Hospital Pharmacy
University of California,
San Francisco

From Mr. Waggener's Mailbag

July 20, 1970

Dear Mr. Waggener:

An exhibit on drug abuse may now be obtained on loan from Eli Lilly and Company by state, county, and local pharmaceutical and medical associations and by schools of pharmacy and medicine. The exhibit is designed for display at state or county fairs, health fairs, or other appropriate gatherings of the general public under the sponsorship of the association and/or school.

The eight-foot-long exhibit features an 11-minute slide-tape presentation entitled "Students Look at Drugs," in which six students describe the availability and use of drugs as they see them and offer suggestions for alleviating the problem.

Space is provided above the film screen for identification of the sponsoring organization. To the left of the exhibit is a storage compartment on the top of which handouts such as drug abuse educational material, health information pamphlets, or other literature may be placed for distribution to visitors.

A LaBelle tape cartridge deck is used with a carousel slide projector to advance the slides automatically and provide narration. The unit runs continuously.

Although relatively maintenance-free, the unit is subject to failure, as with any piece of equipment containing moving parts. For this reason, any organization borrowing the exhibit should arrange to have someone on hand at all times during the show hours.

Eli Lilly and Company will pay shipping costs to the exhibit site and return to Indianapolis. *Any cost involved in obtaining the exhibit space must be borne by the sponsoring organization.*

A limited number of exhibits are now available for loan and may be obtained on a first-come, first-served basis. If you have occasion to borrow the exhibit, please give us:

1. Name and dates of the show, including set-up date.
2. The exact name of the sponsoring organization (this will allow us to prepare the identification panel).
3. Precise shipping instructions (e.g., street address, building name, booth number).
4. The name and address of one individual who will assume responsibility for setting up the exhibit, seeing that it is properly manned during show hours, and seeing that the exhibit is dismantled, repacked, and returned promptly to Indianapolis. Note: *Two men are required to set up the exhibit as well as dismantle it.* Instructions accompany the exhibit.

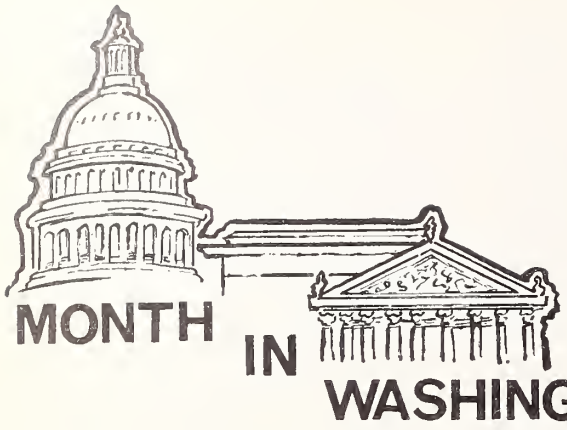
Please submit requests as early as you can. *One to three weeks are required to ship to your location,* depending on the distance from Indianapolis.

Requests should be addressed to Eli Lilly and Company, marked for the attention of the Professional Relations and Services Department, M-501, Indianapolis, Indiana 46206.

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Benj. A. Smith, Manager
Professional Relations and Services

Two-Thirds of Tax Dollar Goes to Washington

"Today, more than two-thirds of every tax dollar goes to Washington and less than a third stays home. Not long ago the proportion was exactly the opposite. This presents an economic enigma—one to which a solution must be found."—E. Hornsby Wasson, National Chamber vice president and chairman of the Pacific Telephone and Telegraph Co.



MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

A DEMOCRATIC and a Republican member of the House Ways and Means joined to introduce The American Medical Association's Medicredit plan for federally subsidized national insurance.

THE co-sponsors of the legislation (H.R. 14567) were Reps. Richard Fulton (D., Tenn.) and Joel T. Broyhill (R., Va.). Both are members of the House Ways and Means Committee which has jurisdiction over such legislation. Soon after introduction of the Fulton-Broyhill measure, Rep. Omar Burleson (D., Tex.), also a member of the Ways and Means Committee, and Rep. John Jarman (D., Okla.), chairman of the House Commerce Subcommittee on Health, introduced an identical bill. Other members of the house from both major political parties indicated they also would become co-sponsors.

FULTON, who 18 months ago introduced legislation based on the Medicredit principles for financing private health insurance for individuals, told the House that the new bill "represents . . . a vast improvement over its predecessor by reason of the fact that it encompasses a built-in mechanism for cost control." He referred to mandatory peer review.

SPEAKING for himself and the measure's co-author, Rep. Joel T. Broyhill (R., Va.), Fulton said the time for national health insurance has come.

"AND WHETHER we're talking about the Rockefeller approach, the AFL-CIO approach, the Kennedy approach, or the approach taken by the Committee of 100, all of them advocate sweeping changes in our health care system," Fulton said.

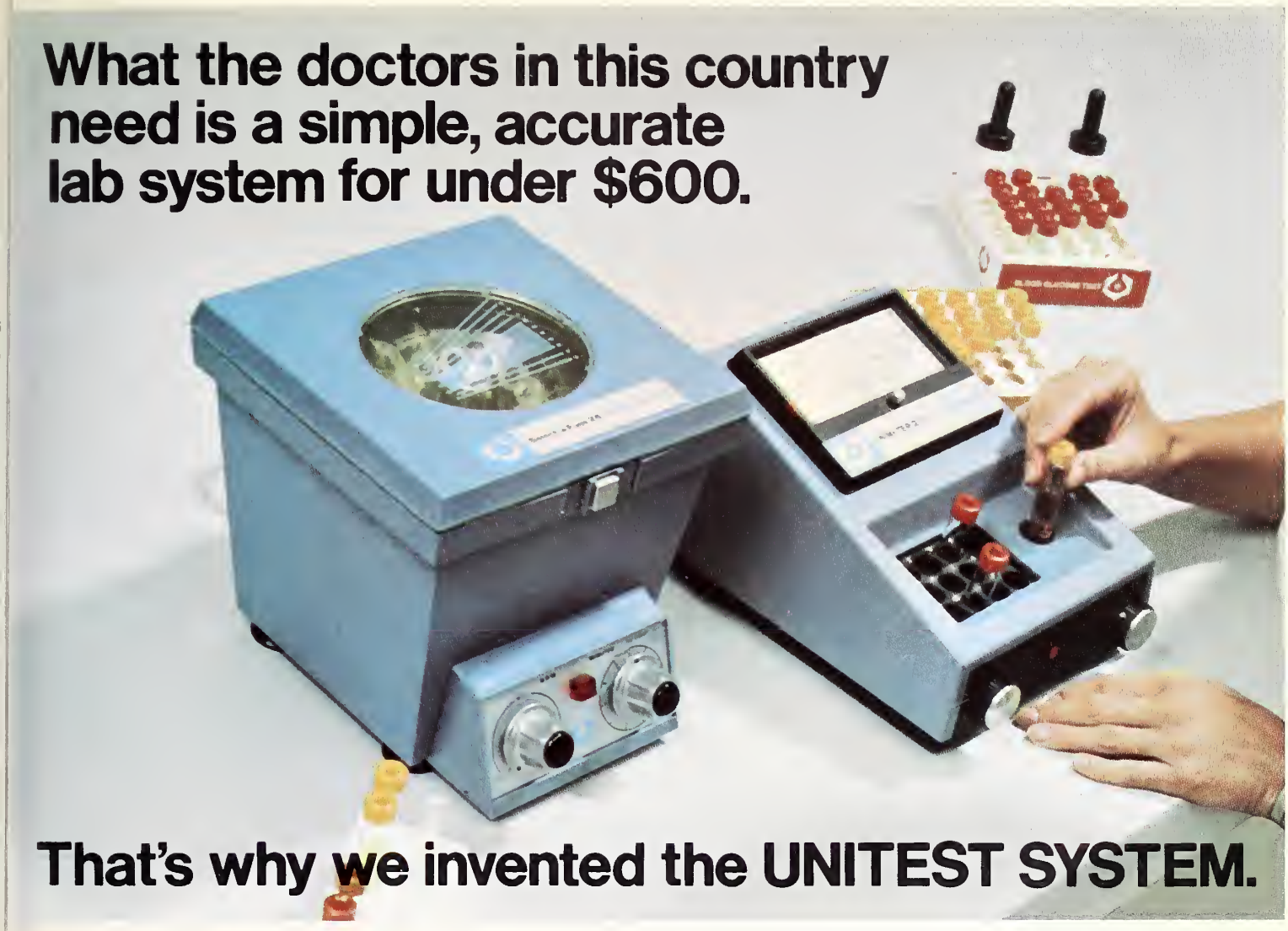
"AN across-the-board national health insurance plan, operated regardless of need, will carry a price tag of sobering size. And no such plan I have yet seen includes—at least to my satisfaction—a mechanism which promises effective cost control at the taxpayers' money.

"THIS brings us to an essential element of Medicredit—its provision of peer review. This bill calls for a constant and unremitting policing mechanism."

THE OTHER two parts of the Medicredit legislation would provide for the federal government financing or assisting in the financing of medical and hospital care for individuals and their dependents through participation in the cost of insurance policies of their choice—100% premium payment for

Continued on page 991.

What the doctors in this country need is a simple, accurate lab system for under $600.



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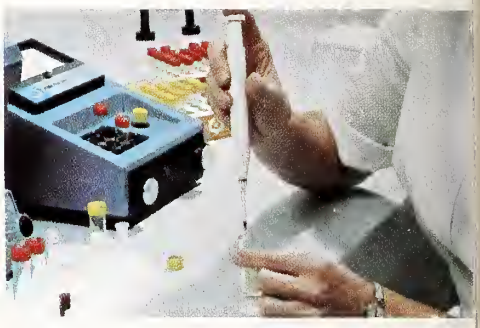
The Select-a-Fuge 24 — The most advanced centrifuge in its category ever developed . . . a single unit capable of performing *three* centrifugated preparations where at least two units were previously required . . . and in the shortest possible time for each specimen involved. The Select-a-Fuge 24 can prepare urine specimens at the low speed of 4000 rpm . . . or perform uniformly consistent serum, plasma and hematocrit results at 10,000 rpm. Other preparations requiring graduating intermediate speeds may also be conducted. Select-a-Fuge 24 does all this without changing equipment, without adding or removing parts.



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Continued

the low-income groups, and graduated participation in the payment of premiums for other persons, based on their federal income tax liability.

CONGRESS is not expected to take up this year proposals for national health insurance. But reaction to the AMA peer review plan has been highly encouraging, and prospects appeared good that Congress would approve such a plan this year for medicare and medicaid. Sen. Wallace F. Bennett (R., Utah), a senate finance committee member, directed the committee's staff to work with AMA staff representatives in drafting such legislation as an amendment to a bill revising medicare and medicaid.

IN A SPEECH on the Senate floor, Bennett said there is deep concern over the high costs of medicare and medicaid. He complimented the AMA on advancing peer review as a means of curbing these costs. He said:

"I BELIEVE the American people are justifiably concerned over the tremendous costs of health care. Much of that concern, it seems to me, is a product of a very real feeling that we are not getting what we are paying for. I believe, equally, that much of the apprehension, anxiety, and suspicion now prevalent—for better or worse—with respect to those responsible for health care would disappear if professional standards review organizations were established and functioned effectively. It seems to me that the American people are entitled to know that American medicine shares their concern—and more importantly———proposes to do something substantial about it through means of professional standards review organizations . . . .

"I BELIEVE THAT physicians, properly organized and with a proper mandate, are capable of conducting an ongoing effective review program which would eliminate much of the present criticism of the profession and help enhance their stature as honorable men in an honorable vocation willing to undertake necessary and broad responsibility for overseeing professional functions. If medicine accepts this role and fulfills its responsibility, then the Government would not need to devote its energies and resources to this area of concern. Make no mistake, the direction of House-passed social security bill is toward more—not less—review of the need for and quality of health care. I believe my amendment would provide the necessary means by which organized medicine could assume responsibility for that review."

BENNETT said that, under his amendment, review groups would have responsibility for reviewing "the totality of care provided patients—including all institutional care." That responsibility he said, would be lodged, "wherever possible and wherever feasible," at the local community level. He said:

"LOCAL EMPHASIS is necessary because the practice of medicine may vary, within reasonable limits, from area to area, and local review assures greater familiarity with the physicians in-

Continued

volved and ready access to necessary data. Priority should be given to arrangements with local medical societies—of suitable size—which are willing and capable of undertaking comprehensive professional standards review . . . .

"UNDER the amendment, the Secretary [of Health, Education and Welfare] could use state or local health departments or employ other suitable means of undertaking professional standards review only where the medical societies were unwilling or unable to do the necessary work, or where their efforts were only pro forma or token. Let me emphasize as strongly as possible that the thrust of this proposal is to have physicians, as a group, evaluate physicians and the services they provide and order as individuals."

BENNETT SAID that the review committees should determine that only medically necessary services are provided by physicians, hospitals, nursing homes and pharmacies, and that these services meet proper professional standards.

DISCIPLINARY MEASURES, he said, would be in proportion to the offense and could include: 1) monetary penalties, 2) suspension from federal programs, 3) exclusion from federal programs, 4) civil or criminal prosecution, and 5) steps leading to the suspension or revocation of professional licensure.

CONCERNING the peer review part of his bill—H. R. 18567, ""Health Insurance Assistance Act of 1970"—Fulton said:

"THE APPROPRIATE medical socities would be charged with establishing a peer review mechanism that would, among other things, review individual charges and services, wherever performed; review hospital and skilled nursing home admissions; review the length of stays in hospitals and skilled nursing homes; and review the need for professional services provided in the institution.

"THE PROCESS of ongoing review can have nothing but a salutary effect on the providers of services, thereby cutting down on the occasional or unintentional abuses that would otherwise occur.

"PATTERNS OF ABUSE would be detected, and the abusers either suspended from or excluded from the program. Exclusion could follow action by the Secretary of Health, Education and Welfare upon the recommendation of the peer review committee.

"IN THE CASE of fraud, or other clear intentional misconduct, the peer review committee would be expected to bring charges before the appropriate licensing body.

"AND in the event that a peer review committee was <u>not</u> established by the medical society within a reasonable time, or if established was not functioning, the Secretary of HEW, in consultation with the medical society, would be empowered to appoint a peer review committee that would function."

THE FULTON-BROYHILL BILL would provide that an individual having a tax liability of $300 or less in a base year be entitled to a certificate acceptable by carriers for health care insurance for himself and his dependents. Insurance purchased with such a full-pay

certificate would require no beneficiary participation in health care charges. Federal contribution to insurance purchased by individuals under this part of the program would be scaled in favor of low-income taxpayers—from 98% if the taxpayer's base year income tax is between $301 and $325, to 10% when his tax liability exceeds $1,300. Basic benefits in a 12-month policy period would include 60 days of inpatient hospital care. To encourage utilization of less expensive facilities, two days in an extended care facility would count as one day of the 60 days allowed. Other basic benefits would include emergency and outpatient services, and all medical services provided by a doctor of medicine or osteopathy.

A SUPPLEMENTAL coverage could provide, in addition, one or more of the following: prescription drugs not otherwise covered, additional days of inpatient and extended care services, blood in excess of three pints, personal health services when furnished on written direction of a physician, diagnostic and therapeutic services, and catastrophic coverage of all hospital and medical costs, up to $25,000, after the first $300 of incurred expenses borne by the beneficiary.

FCC APPROVES SPECIAL EMERGENCY RADIO SERVICES

THE Federal Communications Commission approved an application for local medical societies to operate special emergency radio services for their members.

THE FCC said that such hookups could carry only messages relating to the safety of life or urgent medical duties of users. Such emergency radio service must be cooperative, with members assessed pro rata shares for cost of operation, the FCC said.

PREVIOUSLY, individual physicians have been allowed to use emergency radio frequencies and to form groups of physicians for such hookups, but societies representing all physicians in an area have been restricted by FCC regulations.

THE FCC SAID in its ruling:

"THERE IS merit in the plan to use these stations on a coordinated basis with telephone answering services now operated by medical societies and to dispatch messages from central points where society records are readily available to assist in locating a physician when called . . . . The proposal gives promise of fostering the opportunities for service in remote, rural regions . . . [and] would permit the establishment of parallel systems for emergency communications which would be in existence and available for use in times of national crises."

MEDICAL SOCIETIES that petitioned the FCC included Academy of Medicine of Cleveland and Cuyahoga County, Fayette County, Fresno County, King County, Los Angeles, Maricopa County, Montgomery County, Oklahoma County, San Joaquin, Milwaukee County, Sacramento County, and Travis County. They were joined by the American Medical Association. ◄


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The Journal of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
Volume 63 — September 1970 — Number 9

Almost all football deaths are due to brain or spinal cord injuries. Early recognition, careful transportation, and alert clinical care will minimize seriousness. Good physical conditioning, proper equipment, good coaching, and "head-up" blocking and tackling are the best preventives.

Head and Neck Injuries in Football*

JOSEPH C. MAROON, M.D.**
Indianapolis
THOMAS HEALION, B.S.†
Bloomington

IN 1968, 40 athletes died in the United States as a direct result of football injuries. On a player-exposure basis, the incidence is less than 3/100,000 participants.[1] This is exceptionally low when one considers that motoring accidents alone annually account for approximately 58 deaths per 100,000 young men in the same age range.[2] To be emphasized, however, is the fact that all direct football fatalities were due to injuries to the brain or spinal cord.

At the junior high school and high school levels, part-time team physicians and trainers are frequently called upon to diagnose and manage acute athletic injuries involving the nervous system. Aware of the potential complications of such injuries, even the most sanguine physician is alarmed by the sprawled, motionless form of an athlete following a crushing tackle. Although many physicians feel that examination of the neurologically disabled individual is a lengthy process, reliable only when done by a specialist, the initial management of an athlete with a head injury is more dependent on what to look for rather than neurological expertise.

The purpose of this paper is to provide the physician interested in sports medicine with a general outline of the neurosurgical principles to be followed in the prevention and in the initial management of the most frequent football injuries to the nervous system.

Injuries to the Head

An understanding of cerebral concussion is fundamental in the management of all head injuries. To eliminate semantic confusion, the following definition adopted by the Congress of Neurological Surgeons is used: "A cerebral concussion is a clinical syndrome characterized by immediate and transient impairment of neural function such as alteration of consciousness, disturbance of vision, equilibrium, etc., due to mechanical forces."[3] Note in particular that complete loss of consciousness is not a necessary part of this condition.

As an aid to evaluation and management, this definition may be expanded to include mild, moderate, and severe forms of cerebral concussion.[4] A mild concussion is exemplified by the athlete who, following a hard blow to the head, experiences transient neural impairment characterized by headache, tinnitus,

* Awarded the 1970 Ensminger Award by the Indiana chapter of the American College of Surgeons. This work was supported by CVD Research Grant #PHS NB 06793-03.

** Resident in Neurological Surgery, I.U. Medical Center, Indianapolis 46202.

† Head Athletic Trainer, Department of Intercollegiate Athletics, Indiana University, Bloomington 47401.

Reprint requests should be directed to Dr. Maroon.

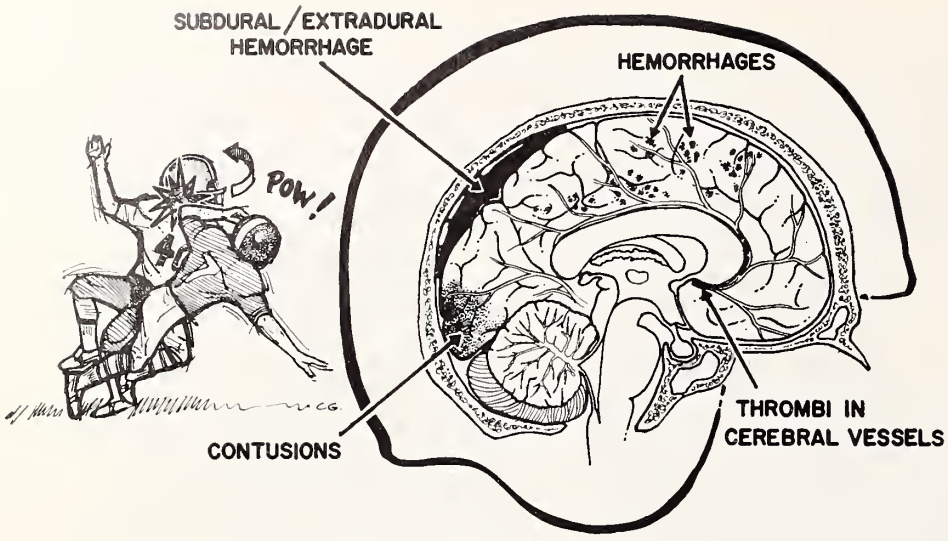


FIGURE 1
POTENTIAL cerebral injuries resulting from a blow to the head.

ataxia or confusion. There is no loss of consciousness and recovery is rapid.

This athlete should be removed from the game for at least several plays. Under no circumstances should he be permitted to resume contact until he can move with his usual dexterity and speed on the side lines, is perfectly oriented as to person, time and place and can answer all questions appropriately.

The moderate cerebral concussion is characterized by definite loss of consciousness with complete recovery occurring in less than five minutes. There is almost always retrograde amnesia, and frequently headache, nausea and dizziness. This player should be removed from the game and should not be permitted to reenter. Close observation by responsible parents or by hospital personnel with particular attention to the level of consciousness, the pupillary response, and movement of the extremities for at least a 24-hour period is mandatory. Permission to return to athletics must not be given if headache, visual disturbance, or any neurological abnormality persists.

In determining when an athlete with a moderate cerebral concussion may return to competition, many physicians invoke the rules set down by numerous state boxing commissions. These organizations impose an automatic suspension of 30 days on any boxer who sustains a knockout, technical knockout, or severe injury of any kind.

Questions frequently arise concerning disposition of the "concussion prone" athlete. Certainly, neurological consultation should be obtained after a second moderate concussion and serious consideration should be given to limitation of activity to noncontact sports. Not infrequently it is found that such an athlete, for various psychological reasons, is quite anxious to quit and welcomes the acceptable "out" provided by a medical excuse.

The severe cerebral concussion is exemplified by the flaccid, unconscious athlete with possible wandering eye movements and little or no response to pain. Unconsciousness lasts longer than five minutes and retrograde amnesia may be severe. Initial evaluation of the unconscious athlete should include an evaluation of the size of the pupils, noting especially any inequality, and also the withdrawal response, if any, to painful stimulation of all four extremities. Immediate hospitalization and neurosurgical consultation is advisable. In the interim an adequate airway must be maintained since hypoxia greatly compounds cerebral injuries.

Figure 1 illustrates the potential brain injuries which may result from a blow to the head. The lesion most directly amenable to surgical treatment and, ironically, responsible for most deaths, is the intracranial hematoma. From an immediate management viewpoint, it matters little if this is a subdural hematoma due to a rupture of bridging veins draining into the superior sagittal sinus or an epidural hematoma secondary to a laceration of the middle meningeal artery and/or vein. Of greatest importance is to remember that a decreasing level of consciousness or persistent unconsciousness and *not* a change in blood pressure, respiratory rate, or pupillary signs is the first and most important sign of a developing intracranial hematoma. Additional useful facts are summarized in Figure 2.

Case Report

The following case summary illustrates one of the potential complications associated with a cerebral concussion.

On September 5, 1959, a 20-year-old fullback for the University of Indiana was kicked in the head during a regular practice session. Although he was not rendered unconscious, he was initially "dazed" and subsequently complained of a headache. Three days later during another supervised scrimmage he was involved in a hard head-on tackle and immediately experienced paresthesias in his entire left side and then lost consciousness. He was hospitalized at the student health center and, although retrograde amnesia lasted approximately four hours, at no time were there localizing neurological signs. He was observed for several days and when the headaches seemed to decrease he was discharged but was not permitted to resume football. After approximately a week, his activity was noted to be "unusual" by his friends and his headaches returned, this time accompanied by photophobia. For these reasons, he was transferred to the Indiana University Medical Center for further evaluation.

On physical examination there were no neurological abnormalities. An electroencephalogram suggested a diffuse abnormality over the right hemisphere and carotid angiography confirmed the presence of a subdural hematoma. The patient was taken to surgery and the hematoma, which was under considerable pressure, was evacuated via two burr holes. The postoperative course was uncomplicated, symptoms subsided, and he made a complete recovery.

INTRACRANIAL HEMATOMAS

1. MOST IMPORTANT SIGN: DECREASING LEVEL OF CONSCIOUSNESS
2. Most common symptoms:
   - Headache
   - Confusion
   - Vomiting
3. Neurological evaluation to include:
   - Level of Consciousness
   - Inspection of Pupils
   - Response to Pain
4. Frequent negative history of concussion
5. Skull fracture usually absent
6. Lumbar Puncture NOT Indicated

FIGURE 2
IMPORTANT points to remember in the athlete with a head injury.

Cervical Injuries

The cervical spine film in Figure 3 was taken of a 17-year-old high school football player who suffered a severe hyperflexion injury of the cervical spine and had a fracture dislocation at the C-5, C-6 level. Immediately following the injury he complained of intense cervical pain and paresthesias in all extremities but was able to move his arms and legs. Although a cervical spine injury was suspected, head and neck support during lifting and transportation was inadequate; when examined by a neurosurgeon upon arrival at the hospital, he was found to be completely quadriplegic, and has remained so to this day.

Between 1931 and 1968, 129 football deaths were caused by cervical cord injuries.[1] The number of athletes made quadriplegic or paraplegic is unknown but must number in the thousands. The tragedy is compounded when an incomplete spinal cord lesion is converted to one of permanent paralysis by mismanagement. No place in medicine is the Hippocratic aphorism, "Primum non nocere," or first do no harm, more appropriate.

Several points regarding the diagnosis and management of acute cervical injuries need to be emphasized. Every unconscious athlete must be managed and transported as if he had a cervical cord injury until proven otherwise. Cervical pain, paresthesias, numbness, weakness or paralysis



FIGURE 3
LATERAL cervical spine x-ray demonstrating a fracture-dislocation at C-5, C-6.

are all common initial complaints which should alert the physician to the possibility of a cervical fracture dislocation. The initial examination may be quite brief, but *must* include a precise evaluation of voluntary movement, and the ability to perceive pain, as well as passive position sense in all four extremities.

It is *not* necessary to remove the headgear in the injured athlete. Not only does it make support of the head with sandbags or towels easier, but its removal can easily produce further neurological damage by flexion or extension of the neck. Upon arrival at a hospital the headgear can easily be cut off with any standard orthopedic cast saw.

All movements should be supervised by a physician. At least five attendants, with one exerting traction on the head and neck in the direction of the body, are used to move the athlete onto an adequate stretcher. Support of the head and neck with such objects as sandbags or towels is mandatory. A physician should remain in attendance until the athlete is under the direct care of a neurosurgeon, orthopedic surgeon, or another physician who is fully apprised of the situation. If the ambulance trip is anticipated to last longer than an hour, proper consideration should be given to the insertion of a Foley catheter to prevent bladder over-distention and to skin care to prevent early pressure sores.

By avoiding further injury and by promptly reducing a fracture-dislocation with skeletal traction, permanent paralysis may be averted and complete recovery of even profound neurological deficits is possible.

The Pinched Nerve

The so-called "pinched nerve" or lateral-flexion neck injury, although not as potentially dangerous as cerebral or spinal injuries, nevertheless is a poorly understood neurological injury that presents many problems to the physician in sports medicine.[5] A common injury, it is exemplified by the athlete who, usually following a hard tackle, drops his arm limply to his side and complains of intense paresthesias and numbness radiating into his shoulder and arm. Weakness initially may be profound, but soon strength returns and the paresthesias give way to a dull ache. Frequently, the symptoms subside completely and the player is permitted to re-enter the game.

The mechanism of this injury is illustrated in Figure 4. When a hard tackle is made, the head and neck are flexed laterally and the shoulder is depressed and abducted. This not only stretches and possibly sprains the lateral ligaments of the spinal column, but also exposes the brachial plexus to direct trauma and stretching. Minor trauma produces transient paresthesias similar to those experienced when the ulnar nerve is traumatized at the elbow. However, with ligamentous injury and moderate to severe direct nerve trauma, it is not uncommon for pain as well as neurological findings including weakness, decreased biceps and/or triceps reflexes, and hypalgesia to persist for weeks.

The management of such injuries is dependent on the severity of symptoms and neurological signs. If a player has a mild injury, is completely asymptomatic shortly thereafter, and has normal strength, he may be permitted to resume contact. Many trainers and physicians would insist, however, that a cervical collar of felt or stockinette be used. If weakness or pain persists, further contact is forbidden and cervical spine x-rays are obtained; physical therapy is instituted, provided there is no evidence of fracture or dislocation. In some cases, cervical traction may be quite useful. When and if sports participation is resumed, a cervical collar is strongly recommended.

Preventive Measures

Proper attention to conditioning, equipment, and fundamental training is imperative if serious and even fatal injuries to the head and neck are to be reduced. There is no excuse for any athlete participating in organized football to have an inadequate or improperly fitted headgear. Most schools presently use the hard-shelled helmets with a sling type suspension that serves to dissipate energy upon impact. Coaches and trainers must supervise the selection and fitting of headgears. If the sling is in contact at any point with the headgear, energy will be transmitted directly to the skull and brain. The consequences of this are exemplified by the following case summary.

A local high school linebacker was admitted to the Methodist Hospital in Indianapolis this past football season for evaluation of persistent headaches and diplopia following multiple head-on tackles during a game. He volunteered that the suspension in his headgear was "flush" against the plastic shell, but he did not take time to adjust it even though a severe jar was felt with each tackle. Carotid arteriography subsequently demonstrated a small subdural hematoma which was successfully treated.

Faceguards also must be custom-fitted so they are as close to the face as possible in order to give maximal peripheral vision and decrease the leverage that may be exerted if the guard is grasped. Properly-fitting shoulder pads are extremely important in the prevention of lateral-flexion injuries to the neck. High fitting pads are most effective in limiting lateral flexion and provide the most protection. The low slung pro-type shoulder pads, especially in the thin-necked athlete, makes one especially vulnerable to this injury.

In fooball, more than any other sport, it is essential to develop strong neck muscles if serious cervical injuries are to be prevented. Routine neck-strengthening exercises, including isometrics, should be a part of each day's calisthenics. The importance of this is no better emphasized than by Earl Blaik, former Army

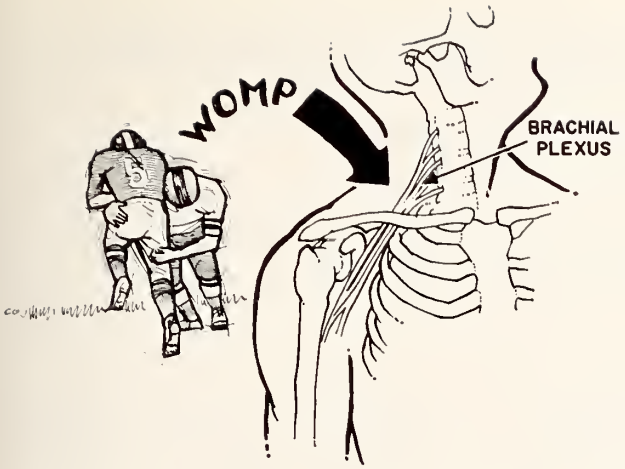


FIGURE 4
THE mechanism of the cervical lateral-flexion or "pinched nerve." injury.

coach, who made the following comment after the death of one of his football players from a broken neck: "But no matter the rules, football is not for the player without strong neck muscles, especially if his neck conformation is unusually long. After S——'s death, I never allowed a boy with a long neck to play, no matter his desire, unless his neck muscularity was well above average. I emphasized more than ever the importance of neck strengthening calisthenics and more than ever I hammered at a boy learning to block and tackle with his head up, for if the head is not bent the neck cannot be broken."[6]

Finally, it is necessary for trainers and physicians to remind coaches that the practice of "spearing" or "goring," that is, forcefully driving the head instead of the shoulders into an opponent while blocking or tackling, is to be vigorously condemned. The head is not a battering ram and head-up, shoulder tackling greatly diminishes the possibility of hyperextension, hyperflexion, and compressive injuries to the cervical vertebrae.

Summary

Although rare, practically all football fatalities are caused by injuries to the brain or spinal cord. Intracranial hematomas and cervical fracture-dislocations are the lesions responsible for most deaths. The most common symptoms and signs, and the suggested initial management of both of these conditions, are discussed and illustrated with case histories.

The following points are particularly emphasized: (1) A decreasing level of consciousness is the first and most important sign of an intracranial hematoma; (2) All unconscious athletes should be managed as if they had a cervical spine injury until proven otherwise; and, (3) Prevention of serious head and neck injuries depends on proper-fitting equipment, the development of strong neck muscles, and detailed coaching in proper "head-up" blocking and tackling technics. Because of its disconcerting frequency, the mechanism and management of the cervical lateral-flexion or "pinched nerve" injury is also discussed.

Acknowledgements

The illustrations were prepared by Craig Gosling of the Department of Medical Illustrations, Indiana University Medical Center.

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Current Trends in Treatment and Prevention of Meningococcal Disease

JACKSON G. CROWDER, M.D.
*Indianapolis**

NEISSERIA meningitidis, a gram negative diplococcus, is a well known cause of purulent meningitis. Infections with this organism have occurred in epidemics and have been a problem particularly in closed populations such as military recruits.

The organism is spread by respiratory droplets. Persons who acquire the organism carry it in the nasopharynx for variable periods of time. The majority of carriers suffer no ill effects. In a small minority of persons so infected, the organisms gain entry into the blood stream and produce bacteremia or meningitis.

Most meningococcal isolates belong to one of four serologic groups designated as A, B, C, and D. These correspond respectively to Types I, II, IIa, and IV in the previous classification. Other minor subgroups have been found, and some isolates are nontypable with currently available antisera.

Group A meningococci were most frequently isolated in the past and were the major cause of epidemics during the world wars as well as other epidemics. Group A meningococci were uniformly sensitive to sulfonamides. Treatment with these drugs was successful in bacteremia and meningitis, and the nasopharygeal carrier state could be eliminated with them. By treating all members of a closed population with a sulfonamide, the nasopharyngeal carrier rate would fall to near zero, and an epidemic could be halted.

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Sulfonamide Resistance

Although Group B meningococci demonstrating *in vitro* resistance to sulfonamides were isolated as far back as 1938,[1] sulfonamide resistance did not become a clinical problem until 1963, when an outbreak at the San Diego Naval Training Center was found to be due to sulfonamide resistant Group B organisms.[2] The proportion of organisms resistant to sulfonamides has increased, so that at present, in both the military and civilian population, the majority of meningococcal isolates are sulfonamide resistant. For several years after 1963, Group B organisms were most frequently isolated. More recently they have been supplanted by Group C organisms. Since the majority of isolates at present are resistant to sulfonamides, these drugs are indicated neither in the treatment of meningococcal disease nor in prophylaxis, unless one knows by *in vitro* testing that the organism is sulfonamide sensitive.

The treatment of choice for meningococcal meningitis or other serious meningococcal infection is penicillin G, given intravenously in a dosage of 20-30 million units daily. This therapy is as efficacious as sulfonamide therapy was formerly. There is no indication for giving penicillin and a sulfonamide, as there is no evidence that the combination is superior to penicillin alone, even in treatment of disease due to sulfonamide sensitive organisms. There have been no reports of meningococci resistant to penicillin.

Chloramphenicol has been recommended as an alternative antibiotic in patients allergic to penicillin.[1] Although cephalothin (Keflin)® has been used as an alternative to penicillin G for infections in penicillin allergic patients, there have been reports of failure or suboptimal response in treatment of meningococcal meningitis with this antibiotic.

Treatment of meningococcal carriers and prophylactic treatment of contacts have been more difficult. Penicillin G, while effective in treatment of meningococcal disease, has not been effective in permanently eradicating the carrier state for unknown reasons. Neither have several other antibiotics to which meningococci show *in vitro* susceptibility.

Treatment and Prevention

The approach to the problem of treatment of carriers and prevention of disease has been made in two ways. These are the search for an effective antibiotic and the development of an effective vaccine.

Of the antibiotics tested for effectiveness in elimination of the carrier state, rifampin has been the most promising. Rifampin is synthesized from natural rifamycin B and has been effective in treatment of tuberculosis. It is also active against most gram positive and gram negative cocci and some gram negative bacilli. In a study of treatment of meningococcal carriers, 600 mgm daily for four days reduced the carrier rate by 93.3%.[3] This effect was sustained for four weeks. However, other studies have demonstrated rapid development of resistance by other bacteria to rifampin, and only further

experience will show if this occurs with meningococci. Rifampin is not yet released in this country.

Encouraging results were obtained in a recent study in which army recruits were immunized with a single injection of a high molecular weight polysaccharide vaccine from Group C meningococci.[4] Compared with unimmunized controls, there was an 87% reduction in meningococcal disease due to Group C organisms. This was felt to be due both to increased local immunity with decreased nasopharyngeal colonization and increased humoral immunity with resistance to blood stream invasion. However, the immunity was group specific and there was an increased attack rate due to Group B organisms in the vaccinated group. Thus it would appear that simultaneous immunization with several types will be necessary to eliminate most cases of disease. Group A polysaccharide has been prepared but not field tested, and a suitable antigen is not yet available from Group B.

With the propensity of the organism to develop resistance to antibiotics, effective vaccines may be more useful in prevention of meningococcal disease.

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ELECTROCARDIOGRAM OF THE MONTH

Myocardial Infarction: "Slow" Ventricular Tachycardia

*CHARLES FISCH, M.D.**
Indianapolis

ONE of the most common ventricular arrhythmias complicating myocardial infarction is an accelerated ventricular rhythm ("slow" ventricular tachycardia). The rate of this arrhythmia is usually much slower than that of the ordinary ventricular (frequently varies from 75 to 100); it appears and disappears gradually without an accurate coupling so characteristic of repetitive ventricular tachycardia; it may last for only a few beats but most importantly it is, as a rule, a benign ventricular arrhythmia. In our experience it requires no treatment, and in fact is highly resistant to Lidocaine.

The accompanying figure is a classical example of such an arrhythmia. The bottom row demonstrates the marked elevation of ST segment of an acute myocardial infarction. In AVR, the last two complexes represent normal sinus rhythm while the remainder of the strip represents the "slow" ventricular tachycardia. In AVL the first six and the last three QRS complexes represent the "slow" ventricular tachycardia, the eighth and ninth complexes are normal sinus beats, while the seventh is a fusion between the impulse originating in the SA node and the ventricle, proving the ventricular origin of the arrhythmia. ◄

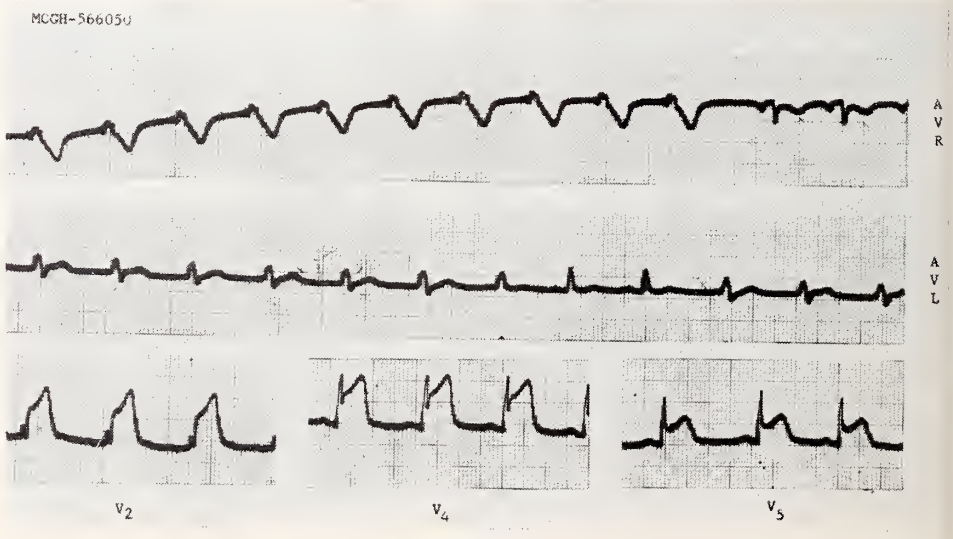
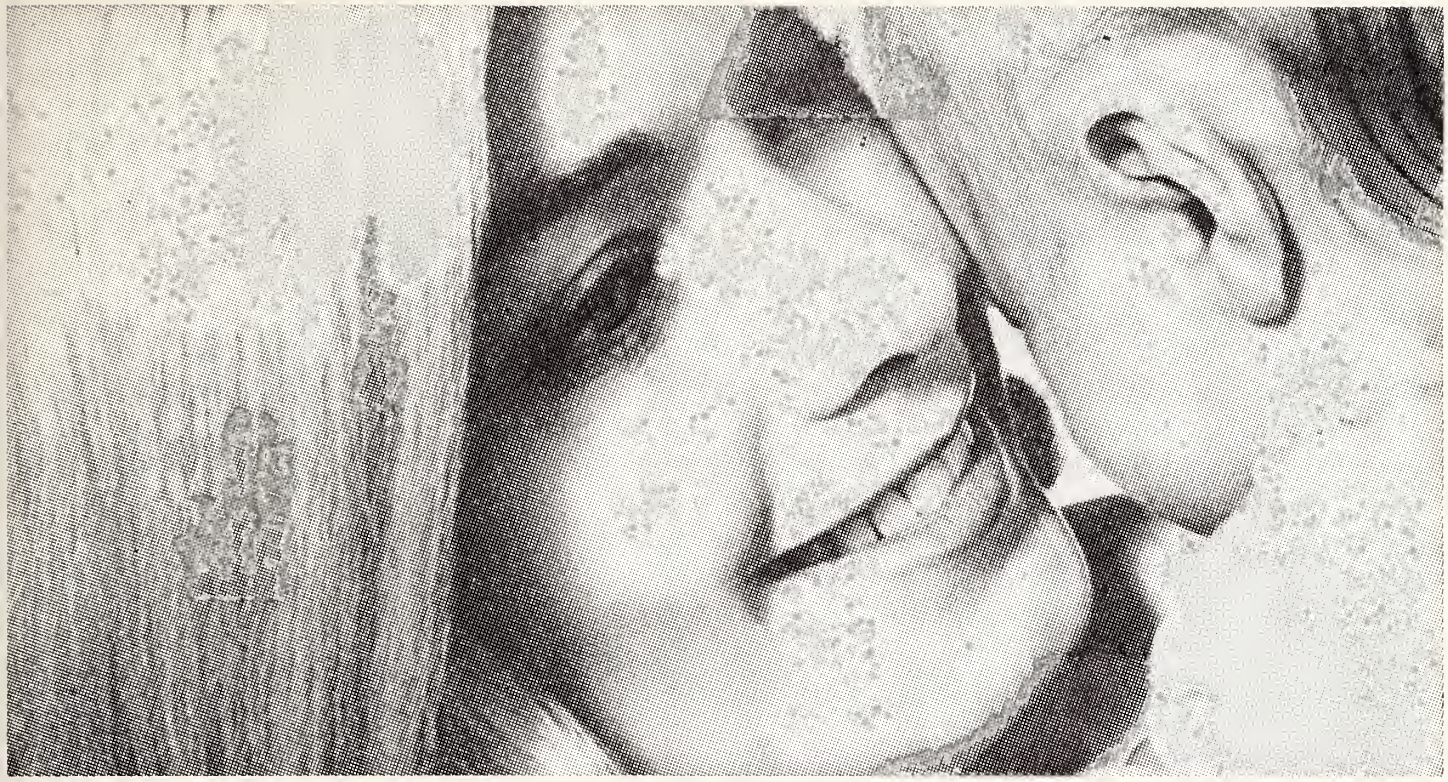


FIGURE 1
ACCELERATED ventricular rhythm ("slow" ventricular tachycardia). For details see text.

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.



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*WARREN L. WILLIAMSON, M.D.***
*ERICH K. LANG, M.D.**
Shreveport, La.

A 67-year-old white male was readmitted to the hospital in April, 1970, with a four to five day history of mild abdominal discomfort and jaundice.

The past history was significant inasmuch as a Whipple's procedure had been performed for carcinoma of the ampulla of Vater some two years earlier. In the interim, the patient had been entirely asymptomatic and had regained to his normal weight.

At the time of admission, physical examination revealed an elderly white male in fair nutritional state but obviously jaundiced. A right inguinal hernia was noted. The abdomen did not appear to be tender nor distended.

Laboratory findings demonstrated a total bilirubin of 11.1, an alkaline



FIGURE 1
A transhepatic cholangiogram demonstrates the anastomotic site between the common duct and a jejunal loop to be almost completely occluded. Typical tumor shoulders are seen to protrude into the common duct identifying the presence of recurrent neoplasm involving the anastomotic site.

* From the Department of Radiology, L.S.U. School of Medicine in Shreveport, Shreveport, La.

** From the Department of Surgery, Confederate Memorial Medical Center, Shreveport, La.

phosphatase of 14.08, and serum amalase of 63. Otherwise the laboratory findings were essentially normal. During his hospitalization, the bilirubin continued to rise and finally a total bilirubin of 25.84 was recorded.

A barium enema was essentially normal. An upper gastrointestinal series demonstrated a suspicious area at the site of anastomosis which was thought to possibly represent evidence of recurrent neoplasm. A transhepatic cholangiogram was subsequently performed (Figure 1). This study demonstrated an almost complete obstruction of the anastomotic site between the common duct and the jejunal loop. Typical tumor shoulders were demonstrated at this junction segment indicating recurrent neoplasm.

In view of the recurrent nature of the disease, it was elected to furlough the patient and abstain from further surgical intervention.

Comment

The efficacy of transhepatic cholangiography for the identification of tumor recurrence at the anastomotic site between the common duct and a jejunal loop following a Whipple's procedure is illustrated by this patient. The diagnosis of recurrent tumor could be made with great confidence on basis of demonstrable "tumor shoulders" protruding into the common duct. Although the diagnosis was suggested on basis of the characteristic history and progressive jaundice, the affirmation by the transhepatic cholangiogram spared the patient a further exploratory procedure. ◄

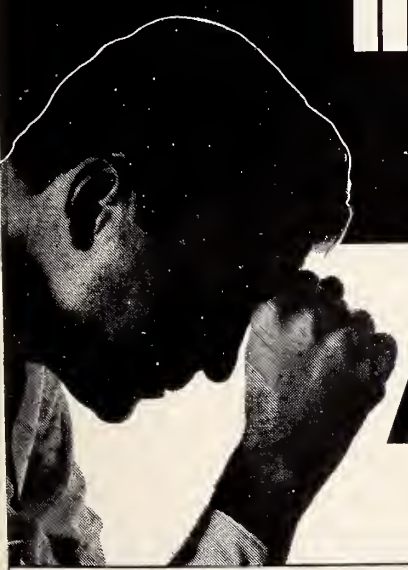
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Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For *essentiol hypertension in odults* the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For *edemo, oscites* or *effusions in odults* initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For *children* the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Dall, J. L. C.: Amer. Heart J. 70:572-574 (Oct.) 1965. **2.** Liddle, G. W.: Ann. New York Acad. Sci. 139:466-470 (Nov.) 1966. **3.** Gantt, C. L.: Diuretic Therapy, DM (Disease-A-Month), Chicago, Year Book Medical Publishers, Inc., 1967, pp. 1-31. **4.** Alexander, S.: Geriatrics 23:131-139 (Nov.) 1968. **5.** Stason, W. B., and others: Circulation 34:910-920 (Nov.) 1966. **6.** Lieberman, F. L., and Reynolds, T. B.: Gastroenterology 49:531-538 (Nov.) 1965.

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Adverse Reactions: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occurs, decrease dosage. If rapid pulse, dizziness or blurring of vision occurs, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

Dosage and Administration: Adults: Two tablets, orally, four times per day, followed by liberal fluid intake. Older children reduce dosage in proportion to age and weight.

How Supplied: Bottles of 50, 500 and 1,000 tablets.

References: (1) Sand, R.X.: New York St. J. Med. 61:2598-2602, 1961: (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961: (3) Haas, J., and Kay, L.L.: Southwest. Med. 42:30-32, 1961: (4) Marshall, W.: Clin. Med. 7:499-502, 1960: (5) Strauss, B.: Clin. Med. 4:307-310, 1957.

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Medical Fee Controls

ROBERT J. MYERS, who recently resigned as Chief Actuary of the Social Security Administration, addressed the Oklahoma State Medical Association soon after submitting his resignation. The resignation was accepted nine days after the speech was delivered.

Mr. Myers' remarks were reported in abridged form in the July 20 issue of *Medical Economics*. Everyone, not just all doctors, but everyone in the United States should read what he said.

In discussing those who wish to establish national health insurance, Mr. Myers said "I believe that this is the great weakness of many of the advocates of national health insurance—namely, that they do not have a real knowledge of many of the complex elements that go into providing high-quality medical care, much as they might claim that they do."

He thinks that the present demand on the part of the socialists for compulsory socialized medicine has been launched and is getting some attention because of the increase in costs of medical care. He points out that, for several years, the general price level has risen by about five percent annually. The general level of earnings has risen by between six percent and seven percent. Physician fees have also risen at about the rate of earnings. He also states that hospital charges have increased by about 15% during the same period, and the fact that hospital care is worth more now than formerly does not prevent people from objecting to paying for something that does not produce immediate personal pleasure.

Mr. Myers should be the best-qualified individual in the country to estimate what socialized medicine would cost. However, he says that no precise cost estimates are possible because there are so many intangibles involved. His best "guestimate" is that, within a few years, after a full range of comprehensive benefits are provided, the cost of the plans would be at least 10% of payroll and could be as high as 15%.

His conclusion is "It seems to me that the advocates of socialized medicine are trying to deceive the general public and sell their old line of goods under a new guise by unfairly blaming physicians for rising medical costs, when instead these are much more due to the rising general price and wage levels and to the trend of hospital costs."

Preservation of the Old Pathology Building

THE Old Pathology Building at Central State Hospital in Indianapolis has been designated by the National Park Service as a building which should be preserved because of its architectural heritage.

Its selection for this honor was made by the chief of the Historic American Buildings Survey of the Office of Archeology and Historic Preservation in 1969. The Historic Landmarks Foundation of Indiana has registered the building for the National Record. If accepted for this distinction, it will become a treasure of the National Park Service and its preservation will be assured.

All this action comes at a propitious time since it coincides with a movement in Indiana to preserve the building and to utilize it as a medical museum. Dr. Charles A. Bonsett of Indianapolis is chairman of the committee for the Preservation of the Old Pathology Building which has enlisted widespread and responsible support for this project.

When the structure was built in 1895, it was conceived as the state's first medical center. In addition to its amphitheater, it has laboratories for pathology, histology, chemistry, bacteriology and medical photography. It was the site of medical edu-

cation in psychiatry and neurology from 1895 to 1955.

It was also the locale for medical research during the tenure of Dr. Walter Breutsch. It was here that much of the investigative work was done on the treatment of tabes and paresis by the inoculation with malaria.

The Old Pathology Building was utilized for medical instruction originally by the Medical College of Indiana and the Central College of Physicians and Surgeons. Later these schools were combined with Fort Wayne Medical College and formed the Indiana Medical College which was a part of Purdue University. This school also used its facilities for classes in neurology, psychiatry and neuropathology. At this time another school, the State Medical College, also held classes here and from 1908 until 1955, Indiana University School of Medicine had the advantage of clinical and pathologic teaching by the staff of Central State Hospital.

A part of the building is now in use but, for the most part, the laboratories are not required and remain in much the same condition as they were at the turn of the century. The suggestion that the solidly-built structure, which is architecturally significant, be preserved as a medical museum and for educational and research activity is a happy one.

Dr. Bonsett's committee has the backing of the Marion County Medical Society, the Indiana State Medical Association, and the John Shaw Billings History of Medicine Society.

The project has the enthusiastic support of Dr. John Keating, the acting Mental Health Commissioner and the Superintendent of Central State Hospital. The Indiana Neurological Society has added their hearty endorsement.

Governor Edgar Whitcomb gave his approval in September, 1969. The approval of Indiana University School of Medicine has been requested and is expected momentarily.

The Indiana Medical History Foundation has been formed for the purpose of providing a legal vehicle to facilitate preservation and restoration of the building. Members of ISMA are urged to actively participate in this splendid medical history program.

Guest Editorials

Assessing Costs of National Health Insurance

WHATEVER you think of Rep. Martha Griffiths' (D.—Mich.) plan for national health insurance — and we think it is a questionable solution — you cannot fault her political timing.

In 1968 candidate Richard Nixon built his power base among the voters of the American middle class and that is the same group that the Democratic congress-woman is talking to with this latest health plan. There is a good chance that she will find the middle-class audience more responsive to the idea than ever before.

As she says, that's because today the middle class is the most worried about medical care costs, which have zoomed in recent years. She points out that the very rich can afford to pay these costs, while the very poor do not have to pay them, thanks to public health plans.

The great majority in the middle, she says, are hit hardest by rising health costs. Today the cost of a serious illness is such that nine out of ten Americans are medically indigent, declares Mrs. Griffiths.

"Health expenditures now amount to $294 for every man, woman and child in the nation," the congresswoman told reporters. "For some middle Americans, this means spending from 10 to 25% of their income on uncontrollable health and medical services."

Mrs. Griffiths would have the nation set up a compulsory health insurance plan under the Social Security program, increasing the payroll taxes to pay the added costs.

The general idea is not new. But there are probably more people willing to listen to it now. When the advocates of this plan promise better health care for lower cost, they are making strong medicine in this day and age. But the people who take the medicine should be warned that what they are most likely to get is poorer health care and higher costs.

There are not many middle Americans who will argue with Mrs. Griffiths' estimate of the situation — in the case of serious illness, the middle-class family can receive worse scars from the bills than from the illness. But her proposed solution does not offer an answer to the problems of high costs — it merely disguises the costs under another heading.

A large part of medical costs are services. These cannot be as easily automated as can the production of goods. If the prices charged by doctors and hospitals are rising, so are the costs that they in turn must pay. These bills will have to be paid by somebody, in some form, whether they are paid by the individual at the time of the treatment, by private insurance prepayment or by tax funds.

As middle Americans, we delude ourselves if we accept the unspoken suggestion that a compulsory health plan can somehow, some way pass those high medical bills on to somebody else.

Middle Americans can pay their medical bills by paying the doctor, by paying private insurance premiums or by paying higher taxes to support socialized medicine — but they must pay them in some form if they are to get the care.

The fact that we pay our medical bills as taxpayers rather than as patients will not guarantee better care at lower cost. If middle Americans have learned anything during the past three decades, they have learned that "free" services they buy with their taxes do not come cheap.

The biggest item on the middle American's budget today is not the

cost of health care, though that is certainly high. The biggest cost is the cost of government, which includes the cost of all those other "free" services we've voted ourselves over the years.—*Dallas Morning News.*

What's Left?

WE thought we were pretty smart after arriving safely in this world, to have missed Infant Mortality and to have not succumbed to the "usual childhood disease." The teen-age years came and went with minimal rebellion. In those days it didn't matter much whether or not we were "committed" or "relevant" and besides, no one bothered to ask us. In due time we were warned against the evils of drinking and smoking. Even the rigors of World War II and the dangers lurking in the Officers Club neither fazed us nor prepared us for the problems of living yet to come. We should have been warned when the Age of Antibiotics arrived in the post-war period and the side effects and complications of the wonder drugs appeared shortly thereafter. Things have never been quite the same since this period of enlightenment. Surveys showed that most of us had either chronic disease or malnutrition from too much good food and that the rest would soon fall prey to these or something even worse. Also, the tensions accompanying success were getting us. Then there was this guilt complex we suffered for having too much, so that it became obvious that if the psychiatrist's couch didn't get us, Big Brother would.

Now it is too late. Our pesticides got out of hand and we polluted the air and water. Everyone knows that starvation certainly awaits the survivors of the Population Explosion. The death-dealing qualities of cigarettes didn't surprise us too much, but the cyclamate fiasco was the last straw. That did it! If we eat too many carbohydrates, obesity, diabetes and arteriosclerosis await us. If we sidestep these with our favorite friendly cyclamate, there is bladder cancer and only the rats know what else.

Sex is certainly on the way out. Even your Congressman knows what happens to the users of contraceptive pills and, on the other hand, a high incidence of sexual activity has been related to increased cancer of the genitalia and in any case, we might be unpatriotically stimulating overpopulation. Besides, the estrogens fed to poultry might have castrated us anyway! What's left?

Guess we might as well get into our "not safe at any speed" car and head home (breathing pure exhaust fumes en route). A supper of contaminated meat and DDT-sprayed vegetables awaits us. Before this poisonous repast, there is time for a highball of liver-destroying whiskey with a choice of polluted water or high-caloric ginger ale for a mixer. Then we can relax in our favorite (probably highly flammable) easy chair and turn on the color TV set for another dose of irradiation. Certainly our faithful leukemia-carrying cat should be on our lap as we contemplate a choice between a carcinogenic cigarette or perhaps a spot of "pot?" Chances are that by morning we may be annihilated by The Bomb or even a poorly aimed ABM which missed The Bomb. With good luck, we might even die a natural death first!—*Massachusetts Physician,* **June, 1970.**

What's Become of U.S. Respect for Work?

A news dispatch from Russia, telling of a government crackdown on loafers, should make us catch our breath in sudden realization of the contrast that is overtaking us here in America.

The new Russian law, applicable to everyone, provides a penalty of one year in prison for "malicious refusal" to work, and two years in prison for a second offense. The penalty is twice as severe for vagrancy and begging. Conceivably, Ivan could get wealthy by scrimping and saving, or by surreptitiously begging or stealing, but for all his rubles he wouldn't be able to buy his own leisure. His friends or relatives would turn him in.

Thus Communism now deals with "the parasitic way of life." Formerly the parasites were just banished to less desirable parts of the country, but few of them reformed, so sterner measures are being taken to make everyone "socially useful."

In America, meanwhile, the work ethic has become something for the dodo birds.

In 31 states not even the *right to work* is protected by law for those who don't join labor unions.

A move is being made in the direction of a guaranteed annual income which would remove the *necessity to work* for those willing to live just above the so-called poverty level.

And when a strike call comes, there often is no practical *possibility of working,* even for those in governmental or other jobs vital to the public welfare. Our teachers, policemen, firemen, postmen, garbage collectors, nurses and transit workers are apt to leave us in the lurch. Industrial workers sometimes walk off in violation of no-strike agreements. Unions build up big strike funds before they decide what their demands will be, or learn what the company will offer.

In many ways, the old work pride is gone.

This is the way we drift, while Russians are toughened up under a work-or-prison law. It should make us wonder where we'll stand vis-a-vis Russia in productive output 20 years from now.—**Arch N. Booth, Executive Vice-President, Chamber of Commerce of the United States, Washington, D.C.**

Editorial Notes . . .

The VA is taking full advantage of the medical and paramedical knowledge gained by

men and women in the armed services. Almost 6000 discharged veterans with medical skills were hired during 1968 and 1969. VA now has the largest personnel authorization in its history and is increasing its recruiting for such skills.

The Upjohn Company cautions that "Diabetic patients currently taking tolbutamide or other chemically related sulfonylurea agents who are under adequate medical supervision should continue on the current regimen until advised by their physicians." This caution follows an FDA report that a recent study showed "no evidence that the combination of diet and tolbutamide therapy as described and used for mild non-insulin dependent diabetes is more effective than diet alone." Upjohn points out that Orinase was used in the study in a fixed dosage for all patients. The study referred to by the FDA tends to show that the oral agents have less effectiveness in regard to cardiovascular complications than diet alone or diet-insulin treatment. Upjohn knows of two other studies which indicate tolbutamide effectiveness in this regard.

The Federal Trade Commission proposed a regulation which will require that advertising of cyclamate-containing artificial sweeteners include a statement that the product may be dangerous to health when taken in large doses, that it should only be used with calorie-controlled diets by diabetics or obese patients under medical supervision, and that medical supervision is essential for safe use.

There are about 3000 Americans attending foreign medical schools. A large proportion of them are in Italian schools; 745 of them in the University of Bologna, "the world's oldest medical school." Others are in two dozen schools in Switzerland, Belgium, France, Germany, Holland, Spain and Mexico. Most of them are good students who could not be accommodated in the U.S., but most are expected to return here for practice. Six-hundred Americans are attending one school in Guadalajara. Italian and Mexican schools are probably going to have more students because the other countries are limiting enrollment of Americans in order to favor their own citizens or to favor the "have-not" nations.

Hospital costs can be lowered by spending less time in them. So says the Health Insurance Institute. Two billion dollars would be saved each year if only one day could be subtracted from each hospital stay. A lot could be saved if only those went to the hospital who really needed to. The Institute is encouraging its member insurance companies to write policies which will favor outpatient diagnosis and treatment. Making early diagnosis economical would reduce hospital bills because elaborate treatment and disease complications would be lessened. Health insurance policy provisions have tended to encourage hospitalization for diagnosis and minor treatment; policies may be written which will reverse this trend.

The Fire Protection Association is emphasizing the fire dangers of disposable bedding, gowns, dishes, etc. in hospitals and nursing homes. They lessen danger of cross-infection and save labor costs but create a trash problem and fire hazard. They are usually slow-burning, but produce large quantities of toxic combustion products, especially when burning in an inadequate air supply. Hospital associations are endorsing fire protection recommendations; nursing home interests usually object for economic reasons.

Mr. William B. Hennessy, president of the American Pharmaceutical Association, speaking at the annual meeting of the United States Pharmacopeia, advocated a new system of prescribing and dispensing drugs. The APhA, he says, advocates that the physician prescribe the drug and the dosage regimen he wants and the pharmacist decide the dosage form and the source of the medication. Hennessy further stated that this system would develop a "new depth of physician-pharmacist-patient relationship."

Comment from *Business Week*: [One of the joint surgery tests that will expand both the number and effectiveness of joint replacement operations is] a national study aimed at lifting tight U. S. government restrictions on using a controversial bone cement to install artificial joints. The Food and Drug Administration still classifies this cement, a common plastic called methyl methacrylate, as experimental for joint surgery. But doctors in Britain and other countries have used the plastic compound successfully for a decade.

The Association for Health Records was organized last year to provide a multidisciplinary approach to the solution of many problems in the medical and health record field. It includes physicians, statisticians, hospital administrators, nurses, computer experts, and many other disciplines. The first interdisciplinary conference will be held this summer. Program will cover standardization of health records, health care information systems, national coverage, retrieval and dispersal of information. The ultimate, although possibly impossible, goal would be the recording of the entire health and medical records of every person in the United States and the ability for a doctor to gain access to that record under authorized circumstances by dialing a central number and having the desired data reproduced by teletype. ◄

Lounge Talk

LLOYD L. HILL, M.D.
Peru

THE goal of this feature is not to schismatize, but rather to call attention to official policies and edicts of organized medicine in order to remind the hierarchy that there is some cognizance of said policies among the membership back home; we do expect effective implementation of said policies. A further objective lies in convincing the grass-roots physician that his representatives in organized medicine have, by and large, been truly dedicated to the preservation of the private practice of medicine.

I hasten to caution those so eager to replace organized medicine with a bona fide union that indeed there is absolutely nothing to prevent the identical situation recurring in the policies of this proposed organization as has occurred in the traditional group. That is to say its members would be well advised to become considerably more active and involved in the modus operandi of the medical union than they have been in organized medicine. Otherwise its purposes most certainly will be subverted in like manner. Would it not appear far more practical, then, to regain control of the more influential traditional organization?

I, as a citizen of this great nation, find I must continually endure the impudence of the liberal establishment and the pilfering of my bank account to finance causes which in my heart I do not support. The reason I am given to justify this coercion is that it appears to be the prevailing national political sentiment at the moment! The activity of the establishment has perverted our judicial system, played havoc with our institutions of higher learning, and closely approached the "pretzelizing" of our federal Constitution—deviously twisting it to satisfy its political whims.

Now, as a member of organized medicine, I hold the view that what is happening to our policies is total desecration of majority sentiment by an arrogant minority. Without arguing the virtues or faults of these policies, they are irrefutably factual. I refer to policies regarding fee assignment, areawide planning, closed panel systems, national health insurance, Medicare, Medicaid . . . to name a few. In each instance named above, the edicts of the delegates have been totally ignored or given merely perfunctory attention by those responsible for custodial care of the policies of organized medicine.

Whether I've been in my "Counting Chamber" counting my fortune or my debts is totally irrelevant. (The unvarnished truth is that the debts flow in as a result of *being drafted* to fight wars on poverty, pollution, progeny—a political "PPP Syndrome".) The fact remains that lucid mandates have been given to the leadership regarding these policy matters. Fairness alone on the part of the leadership should demand more for its members than superficial gestures that are totally ineffectual against the intimidation of the medical profession by ever-scheming bureaucrats.

An important factor instrumental in the policy breakdown of organized medicine lies in the communications field. Even our own publication, *AMA News*, has indeed become farcical in its reporting. To wit—the account of activities at the recent convention in Chicago bears hardly a similarity to the manuscript of the official actions of the AMA House of Delegates. How relieved I was to learn that the vast majority of our AMA delegates voted conservatively and were truly concerned with matters besides abortion and ghetto medicine. Surprising as it may seem to some of my readers, I do not lack compassion or concern for unfortunates in our society. Truthfully there are many charities in which I sincerely believe, but am sorely limited in my support of same as some dreamy-eyed politician keeps promising my money for causes which might give him a bloc of votes. I'm not complaining that Dr. Doherty and his liberal friends fail to support the charities and causes in which I believe. Is it too much to ask that I might decide for myself the charities I care to support and those I care not to?

Through the centuries, while time marches on, human nature remains unchanged. How clever to create the illusion of a changing humanity simply by changing the vernacular. Is there really a physical difference between a "poor person" and a "deprived individual"; a "slum" and a "ghetto;" "charity" and "welfare benefits?" Social problems are as old as mankind itself; yet the solutions for them are constantly changing. Politically, since 1932, the liberals have "held the reins" nationally. Would it not seem reasonable to expect by 1970 to have witnessed a decline in these social maladies? We heard so much hoopla about the innovative sociological breakthroughs of liberal doctrine! By this time, their continued promises ring hollow. Even the distant drummers have long since gone home! How would we ever penetrate the deafening silence of political campaigns if we would hold the liberal politicians to the rules of efficacy with which they beleaguer the commercial industry?

Alas, organized medicine, through one or both of its political arms of AMPAC or IMPAC, has seen fit to support such allies of the medical profession as Senator Vance Hartke to the tune of $5000 and, to a somewhat lesser figure, that great conservative stalwart, Congressman Lee Hamilton. The cliche, "Politics makes strange bedfellows" is certainly a preposterous understatement in these

instances. The Welsh-Handley debacle of I-HOPE a few years ago evidently failed to influence the political wizards of organized medicine. The irony of it all is that professed conservatives administer the funds of AMPAC and IMPAC ostensibly to support conservative candidates and causes. Instead a large portion of the funds are prodigally expended on politicians who seek to destroy free enterprise. Through exorbitant taxation and my own economic ineptitude, I fritter away enough of my money. I certainly do not need the assistance of AMPAC and IMPAC. ◄

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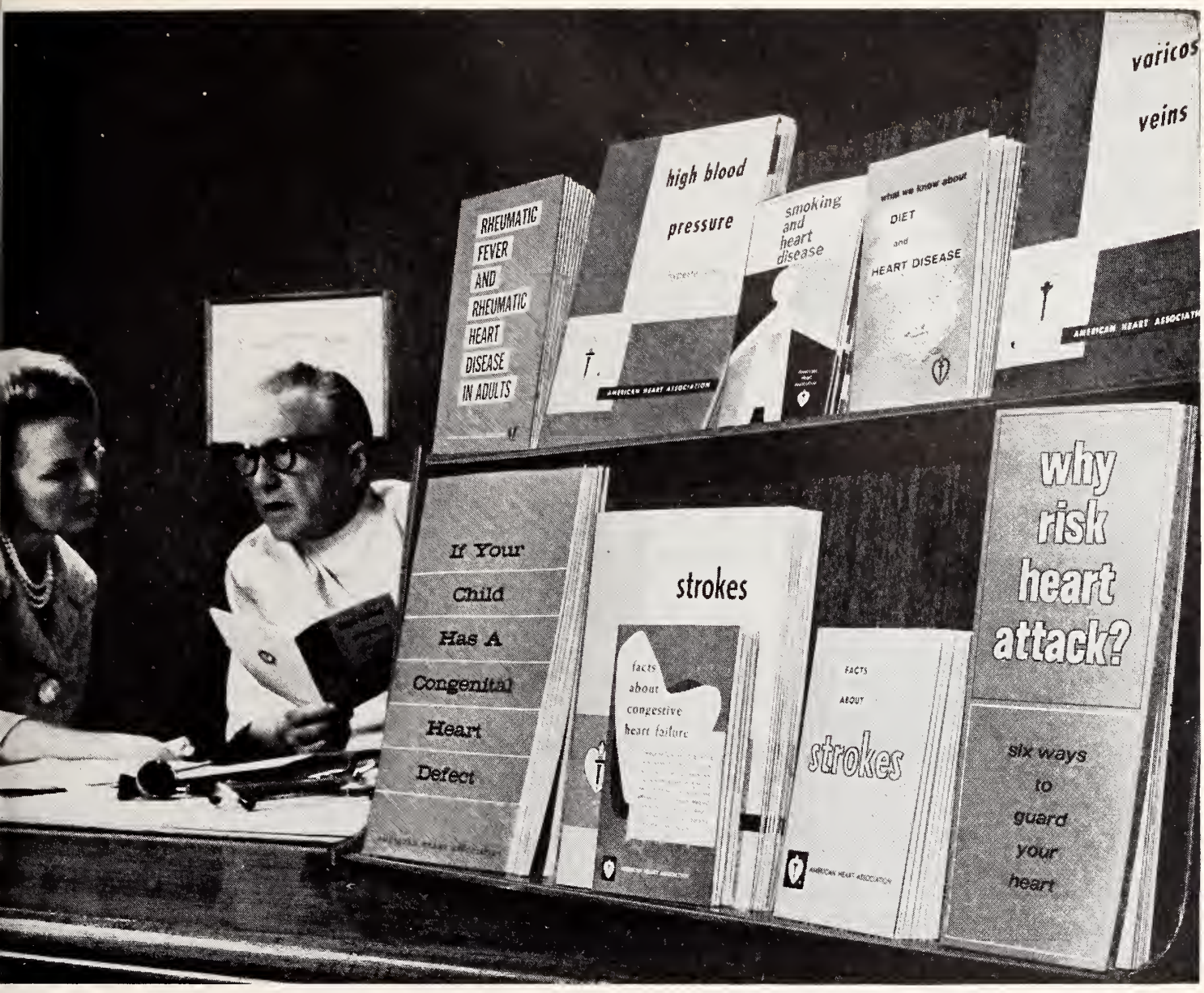
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The Woman's Auxiliary

REPORTS TO ISMA

This year was my first year to attend the AMA as a delegate and I was thrilled to be the presidential delegate. We were a very enthusiastic delegation and we had our full contingency of delegates and alternates. Due to the loss of one of our county auxiliaries this past year we were cut one delegate. This makes us very sad but doesn't keep us down for long as we are determined to get them back and to add many more new ones.



It is not only educational and stimulating to attend something so powerful but renews friendships and makes new ones. The receptions and luncheons for the national officers of the auxiliary were lovely and very well attended.

The business sessions were very rewarding and informative. We are always very interested in what other states are accomplishing and can compare their work with our own. We did not get any special recognition this year but we were still very proud of our addition to the overall total to AMA-ERF and all other auxiliary projects. It seemed a shame that the national contribution to AMA-ERF had to come so close to the goal and yet not attain it. The goal for a half million missed its mark by only two thousand dollars.

We are now enthused about starting our fall projects and workshops. We hope to stimulate enthusiasm in our members so that when it is my turn to give the report at national next year in Atlantic City, I will have a hard time relating all of our accomplishments.

We are also looking forward to the state convention and are working hard to make it very enjoyable for the doctors' wives so it too will be a memorable occasion.

Hope to see many familiar faces in October and to continue our conversations started at the hospitality room Indiana had at the Palmer House in Chicago. It was a very fun time and we met so many new people, too.

Doris M. Clouse

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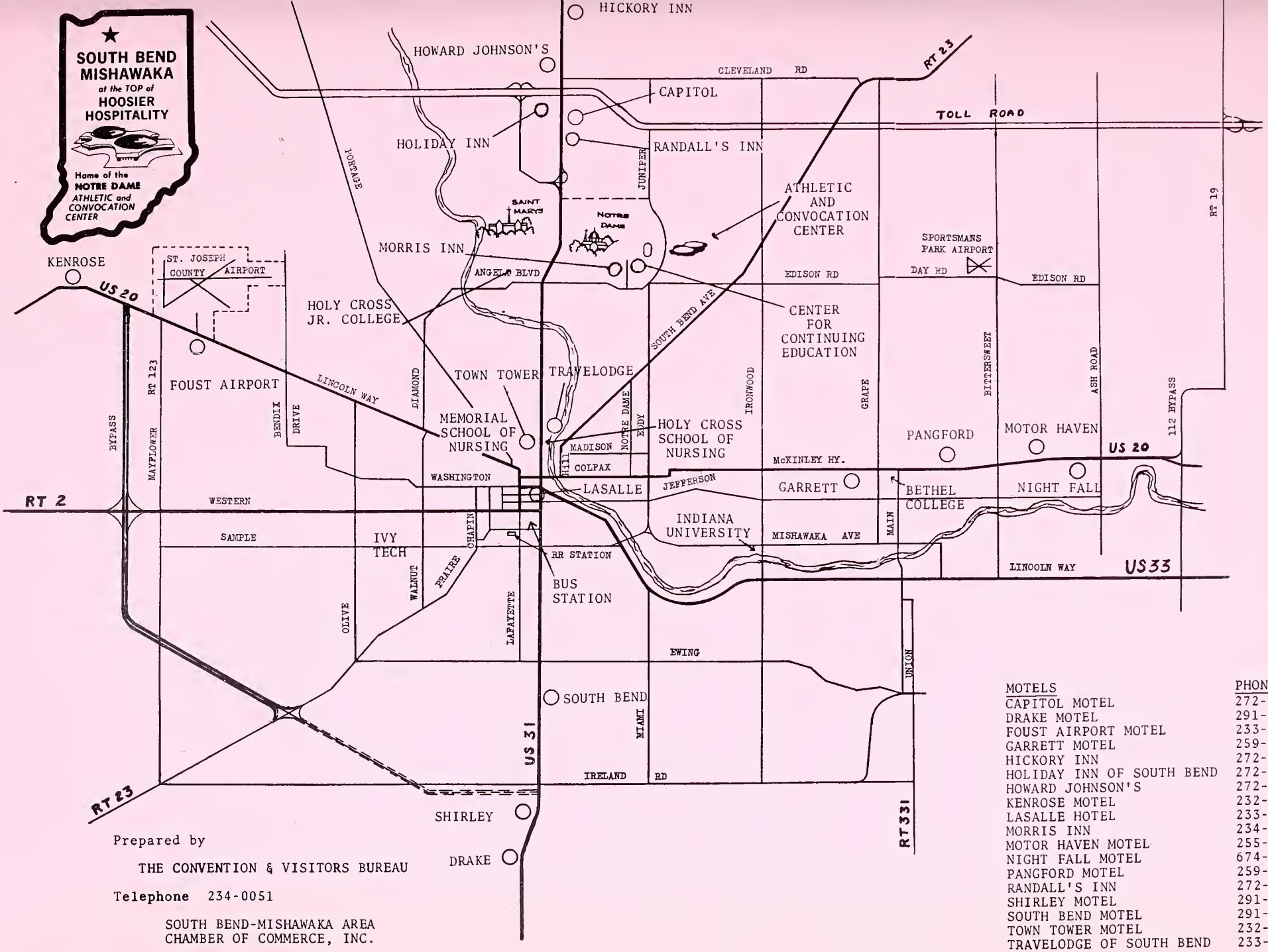
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September 1970



Prepared by

THE CONVENTION & VISITORS BUREAU

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Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Athletic and Convocation Center, Notre Dame University, South Bend, Indiana, October 13, 14 and 15, 1970.

The House of Delegates will be constituted as follows: Marion County, 21 delegates; Lake County, nine delegates; Allen County, six delegates; St. Joseph and Vanderburgh county societies, each five delegates; Delaware-Blackford, Owen-Monroe and Tippecanoe county societies, each three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Harrison-Crawford, Jackson-Jennings, Jefferson-Switzerland, LaPorte, Madison, Parke-Vermillion, Vigo and Wayne-Union county societies, each two delegates; the other 57 county societies, each one delegate; 14 trustees and the ex-presidents, namely, Herman M. Baker, Karl R. Ruddell, M. A. Austin, Paul D. Crimm, W. Harry Howard, Walter U. Kennedy, M. C. Topping, Kenneth L. Olson, Earl W. Mericle, Guy A. Owsley, Maurice E. Glock, Donald E. Wood, Joseph M. Black, Kenneth O. Neumann, Eugene S. Rifner, G. O. Larson and Patrick J. V. Corcoran, and ex-officio, the president, president-elect, executive secretary, the treasurer and assistant treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the president or person presiding shall cast the deciding vote.

All delegates have been certified by their county medical societies. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 9:00 a.m., Tuesday, October 13, 1970, in the Monogram Room, Athletic and Convocation Center, and again at 2:00 p.m., Thursday, October 15, 1970 in the Monogram Room, Athletic and Convocation Center.

The order of business will be as follows:

1. Call to order by the president.
2. Invocation.
3. Roll call and seating of qualified delegates.
4. Announcements from the chair.
5. Tribute to members of the House or those who served the association in an official capacity and who have died since the 1969 session.
6. Reading of the minutes of previous meetings.
7. Introduction of guests.
8. President's Address.
9. Appointment of Reference Committees and assignment of meeting rooms.
10. Unfinished business.
11. Address of president-elect.
12. Report of president of the Woman's Auxiliary.
13. Report of Indiana Chapter Student AMA.
14. Report of president of Blue Shield.
15. Report of executive secretary.
16. Report of treasurer.
17. Report of chairman of the Board.
18. Reports of trustees.
19. Report of *Journal* editor.
20. Report of AMA delegates.
21. Report of State Board of Medical Registration and Examination.
22. Reports of committees and commissions.

COMMITTEES:

(1) Executive
(2) Grievance
(3) Student Loan
(4) Medical-Legal Review
(5) Future Planning
(6) Sports and Medicine
(7) Medicine and Religion

COMMISSIONS:

(1) Convention Arrangements
(2) Constitution and Bylaws
(3) Legislation
(4) Public Information
(5) Governmental Medical Services
(6) Public Health
(7) Voluntary Health Agencies
(8) Inter-Professional Relations
(9) Medical Economics and Insurance
(10) Medical Education and Licensure
(11) Special Activities
(12) Aging
(13) Emergency Medical Services

23. New Business:
    (1) Matters referred by the Board of Trustees
    (2) Matters referred by the Executive Committee
    (3) Resolutions
    (4) Selection of city for 1975 meeting.
        1971—Indianapolis—October 11-14
        1972—French Lick—October 9-12
        1973—Indianapolis—October 16-18
        1974—Evansville—October

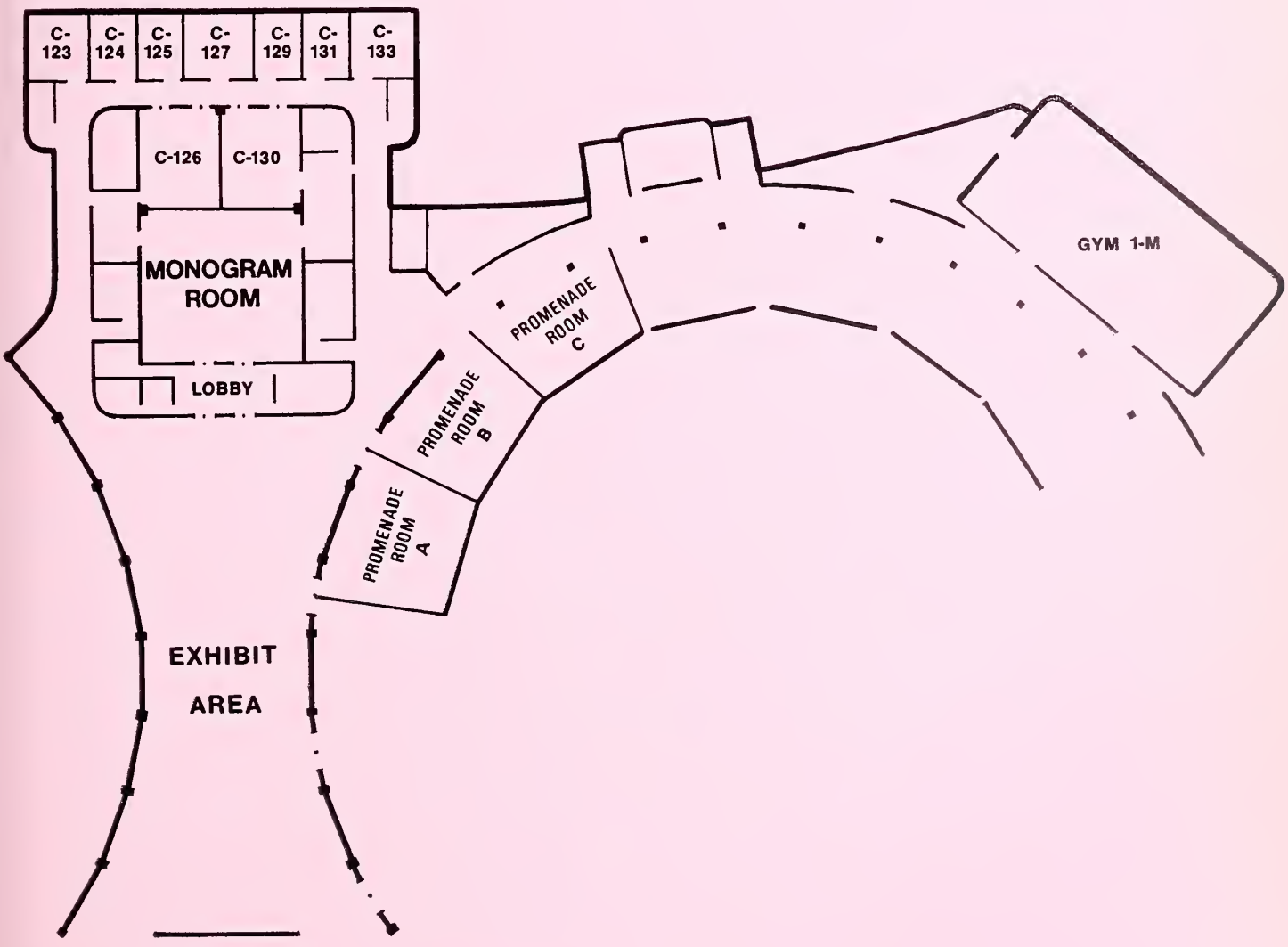
The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following AMA delegates and alternates expire December 31, 1970, and their successors must be elected at the session: delegates to the American Medical Association to succeed Don E. Wood, Indianapolis, Eugene F. Senseny, Fort Wayne and Frank H. Green, Rushville; alternate delegates to succeed James A. Harshman, Kokomo, Eugene S. Rifner, Van Buren and Kenneth O. Neumann, Lafayette.

Delegates from the Third, Sixth, Ninth and Twelfth Districts are reminded that the terms of their trustees will expire October 15, 1970, and new trustees should be elected to succeed the following:

Third District—Donald M. Kerr, Bedford
Sixth District—Stephen D. Smith, Knightstown
Ninth District—Peter R. Petrich, Attica
Twelfth District—William R. Clark, Fort Wayne

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER, *Executive Secretary*



HOUSE OF DELEGATES

Indiana State Medical Association

South Bend—October 13, 14, and 15, 1970

County and Delegates	Alternates
ADAMS (1)	
Norman E. Beaver, Berne	
ALLEN (6)	
Jerald L. Andrew, Fort Wayne	William R. Clark, Jr., Fort Wayne
Charles H. Aust, Fort Wayne	Richard W. Emme, Harlan
Fred W. Dahling, Fort Wayne	Ronald G. Kleopfer, Fort Wayne
John S. Farquhar, Jr., Fort Wayne	Edwin E. Morey, Fort Wayne
DeWayne L. Hull, Fort Wayne	Marvin E. Priddy, Fort Wayne
James P. Scudder, Fort Wayne	Jeff H. Towles, Fort Wayne
BARTHOLOMEW-BROWN (2)	
Harold W. Richmond, Columbus	L. L. Gammell, Columbus
Robert Seibel, Nashville	
BENTON (1)	
D. L. McKinney, Otterbein	Thomas J. Stolz, West Lafayette
BOONE (1)	
Don W. Boyer, Lebanon	Thornton Perkins, Lebanon
CARROLL (1)	
T. Neal Petry, Delphi	George W. Wagoner, Delphi
CASS (1)	
Eugene T. Karnafel, Logansport	Richard L. Glendening, Logansport
CLARK (1)	
Norman E. Forsee, Jeffersonville	George M. Wolverton, Clarksville
CLAY (1)	
Stanley Froderman, Brazil	
CLINTON (1)	
Robert A. Hedgcock, Frankfort	Charles K. Bush, Kirklin
DAVIESS-MARTIN (2)	
Robert H. Rang, Washington	Marshall H. Seat, Washington
Robert E. Chattin, Loogootee	E. B. Lett, Loogootee
DEARBORN-OHIO (2)	
F. L. Frable, Lawrenceburg	Leslie M. Baker, Aurora
Gordon S. Fessler, Rising Sun	
DECATUR (1)	
Robert Acher, Greensburg	
DeKALB (1)	
John H. Hines, Auburn	Harland H. Hippensteel, Auburn
DELAWARE-BLACKFORD (3)	
Donald R. Taylor, Muncie	Warren L. Bergwall, Muncie
Ross Egger, Daleville	Lawrence J. Lawson, Muncie
Paul E. Burns, Montpelier	Severino T. Sulit, Hartford City
DUBOIS (1)	
Francis Gootee, Jasper	
ELKHART (2)	
Thomas A. Elliott, Elkhart	Patrick Campbell, Elkhart
James D. Finfrock, Elkhart	Frederick W. Bigler, Goshen
FAYETTE-FRANKLIN (2)	
William F. Kerrigan, Connersville	
Perry Seal, Brookville	
FLOYD (1)	
Marshall H. Buchman, New Albany	
FOUNTAIN-WARREN (2)	
Max Hoffman, Covington	Lowell Stephens, Covington
William A. Ringer, Williamsport	Carl A. Nelson, West Lebanon
FULTON (1)	
Dean K. Stinson, Rochester	J. D. Richardson, Rochester
GIBSON (1)	
	Richard J. Noveroske, Princeton
GRANT (1)	
Robert M. Brown, Marion	Barton T. Smith, Marion
GREENE (1)	
John Woner, Linton	Carl Porter, Jasonville
HAMILTON (1)	
Joseph R. Lloyd, Noblesville	A. Adrian Lanning, Noblesville

County and Delegates	Alternates
HANCOCK (1)	
J. L. Garrison, Cumberland	James T. Anderson, Greenfield
HARRISON-CRAWFORD (2)	
Richard A. Jordan, Corydon	Samuel W. Martin, Corydon
Jesse C. Benz, Marengo	Milton R. May, Laconia
HENDRICKS (1)	
John P. Calhoon, Avon	Joseph C. Kerlin, Danville
HENRY (1)	
Kenneth G. Hill, New Castle	David R. Cain, New Castle
HOWARD (1)	
Warren McClure, Kokomo	R. W. Halfast, Kokomo
HUNTINGTON (1)	
Richard W. Wagner, Huntington	Howard Marks, Huntington
JACKSON-JENNINGS (2)	
Jack E. Shields, Brownstown	Harry R. Baxter, Seymour
William A. Johnson, North Vernon	Forrest D. Ellis, North Vernon
JASPER (1)	
Paul A. Williams, Rensselaer	Robert W. Greene, Rensselaer
JAY (1)	
James Fitzpatrick, Portland	William Cripe, Portland
JEFFERSON-SWITZERLAND (2)	
Howard Jackson, Madison	Robert Johnson, Madison
Noel S. Graves, Madison	
JOHNSON (1)	
Joseph Young, Greenwood	Joseph F. Ferrara, Franklin
KNOX (1)	
Herbert O. Chattin, Vincennes	
KOSCIUSKO (1)	
Wymond B. Wilson, Mentone	
LA GRANGE (1)	
Dean L. Mattox, Howe	M. O. Mellinger, LaGrange
LAKE (9)	
John J. Reed, Hobart	John P. Birdzell, Crown Point
Thomas C. Tyrrell, Hammond	Charles T. Disney, Gary
T. R. Espy, Gary	Daniel T. Ramker, Hammond
Walfred A. Nelson, Gary	Lee H. Trachtenberg, Munster
Charles D. Egnatz, Schererville	Robert A. Church, Munster
William G. Grosso, East Chicago	Robert Goldstone, Gary
J. E. Kopcha, Gary	Donald H. Rudser, Whiting
Joseph H. Sala, Gary	Arthur Goldstone, Gary
L. W. Neal, Munster	
LA PORTE (2)	
Fred Carter, LaPorte	Barbara Backer, LaPorte
John Luce, Michigan City	Frank McGue, Michigan City
LAWRENCE (1)	
Joseph D. McPike, Bedford	George Sorrells, Bedford
MADISON (2)	
Robert D. Williams, Anderson	T. S. Doles, Middletown
William R. Kopp, Anderson	John R. Wagoner, Anderson
MARION (22)	
James H. Gosman, Indianapolis	George A. Clark, Indianapolis
Dwight W. Schuster, Indianapolis	Joseph T. Farrell, Indianapolis
John O. Butler, Indianapolis	Edward R. Gabovitch, Indianapolis
Joseph C. Finneran, Indianapolis	John D. Graham, Indianapolis
I. E. Michael, Indianapolis	Rex M. Joseph, Indianapolis
John W. Beeler, Indianapolis	Gerald J. Kurlander, Indianapolis
Donald M. Schlegel, Indianapolis	Stafford W. Pile, Jr., Indianapolis
Morris E. Thomas, Indianapolis	Hubert N. Grimes, Indianapolis
Malcolm L. Wrege, Indianapolis	George Klutinoty, Indianapolis
Albert M. Donato, Indianapolis	George T. Lukemeyer, Indianapolis
A. Alan Fischer, Indianapolis	Robert N. McCallum, Indianapolis
Gordon C. Jones, Indianapolis	Dennis Nicholas, Indianapolis
Arvine G. Popplewell, Indianapolis	Michael L. Yacko, Indianapolis
Donald E. Stephens, Indianapolis	Robert J. Yingling, Indianapolis
Donald E. Wood, Indianapolis	Richard A. Brickley, Indianapolis
William A. Karsell, Indianapolis	Max E. Freeman, Carmel
Loren H. Martin, Indianapolis	M. Richard Harding, Indianapolis
Edwin S. McClain, Indianapolis	Henry G. Nester, Indianapolis
Charles E. Test, Indianapolis	John N. Pittman, Indianapolis
Hugh K. Thatcher, Jr., Indianapolis	Francis W. Price, Indianapolis
Hugh L. Williams, Indianapolis	Edward F. Steinmetz, Indianapolis
MARSHALL (1)	
Harry Stoller, Plymouth	James Robertson, Plymouth
MIAMI (1)	
Lloyd Hill, Peru	James Guthrie, Peru
MONTGOMERY (1)	
Richard Eggers, Crawfordsville	James M. Kirtley, Crawfordsville

County and Delegates	Alternates
MORGAN (1)	
Robert W. Van Bokkelen, Mooresville	Kenneth E. Comer, Mooresville
NEWTON (1)	
B. E. Imperial, Kentland	M. F. Guzman, Morocco
NOBLE (1)	
Max Sneary, Avilla	J. A. Greenlee, Avilla
ORANGE (1)	
Phillip T. Hodgin, Orleans	C. X. McCalla, Paoli
OWEN-MONROE (3)	
Robert Rose, Spencer	M. S. Brown, Spencer
Thomas O. Middleton, Bloomington	William C. Link, Bloomington
C. William Seagle, Bloomington	Glen D. Ley, Bloomington
PARKE-VERMILLION (2)	
Richard S. Bloomer, Rockville	
John W. Somerville, Clinton	
PERRY (1)	
Fred Smith, Jr., Tell City	Gene E. Ress, Tell City
PIKE (1)	
Milton Omstead, Petersburg	
PORTER (1)	
Martin O'Neill, Valparaiso	Thomas C. Hall, Chesterton
POSEY (1)	
L. John Vogel, Mt. Vernon	John Crist, Mt. Vernon
PULASKI (1)	
William R. Thompson, Winamac	Charles Heinsen, Winamac
PUTNAM (1)	
Fred E. Haggerty, Greencastle	Robert Marvel, Greencastle
RANDOLPH (1)	
Lowell Painter, Winchester	B. D. Wagoner, Union City
RIPLEY (1)	
George S. Row, Osgood	Lloyd W. Hisrich, Batesville
RUSH (1)	
Frank H. Green, Rushville	Stephen D. Smith, Knightstown
ST. JOSEPH (5)	
Louis F. Sandock, South Bend	Alfred C. Cox, South Bend
Richard W. Holdeman, South Bend	Lester D. Borough, South Bend
S. E. Bechtold, South Bend	George M. Haley, South Bend
H. A. Schiller, South Bend	Donald G. White, South Bend
Philip R. Myers, South Bend	Paul A. Macri, Mishawaka
SCOTT (1)	
Thomas Neathamer, Scottsburg	Benjamin Roberto, Austin

County and Delegates	Alternates
SHELBY (1)	
Wilson L. Dalton, Shelbyville	
SPENCER (1)	
Michael Monar, Rockport	
STARKE (1)	
Guy B. Ingwell, Knox	Clark McClure, Knox
STEUBEN (1)	
John J. Hartman, Angola	Donald G. Mason, Angola
SULLIVAN (1)	
Glen McClure, Sullivan	Betty Dukes, Dugger
TIPPECANOE (3)	
Howard R. Marvel, Lafayette	Richard P. Gripe, Lafayette
W. R. Van Den Bosch, Lafayette	Ben Z. Klatch, Lafayette
Robert C. McAdams, Lafayette	Ramon B. DuBois, Lafayette
TIPTON (1)	
Meredith B. Gossard, Tipton	Ray Kincaid, Tipton
VANDERBURGH (5)	
George W. Willison, Evansville	Daniel M. Hare, Evansville
John D. Wilson, Evansville	Victor Johnson, Evansville
Albert S. Ritz, Evansville	Weston A. Heinrich, Evansville
Ray H. Burnikel, Evansville	Larry W. Sims, Evansville
Bernard B. Rosenblatt, Evansville	William D. Ritchie, Evansville
VIGO (2)	
Thomas J. Conway, Terre Haute	Norman Silverman, Terre Haute
Jack G. Weinbaum, Terre Haute	James W. Cristee, Terre Haute
WABASH (1)	
Fred C. Poehler, LaFontaine	William D. Dannacher, Wabash
WARRICK (1)	
Carlos M. Ruiz, Boonville	
WASHINGTON (1)	
Roy L. Fultz, Salem	C. Stanley Manship, Hardinsburg
WAYNE-UNION (2)	
Glen Ward Lee, Richmond	James R. Daggy, Richmond
Tom Shields, Richmond	John Stepleton, Richmond
WELLS (1)	
Truman E. Caylor, Bluffton	Donald W. Meler, Bluffton
WHITE (1)	
Nolan A. Hibner, Monticello	W. Martin Dickerson, Monticello
WHITLEY (1)	
Thomas Hamilton, Columbia City	

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Earl W. Mericle, Indianapolis
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Maurice E. Glock, Fort Wayne
Donald E. Wood, Indianapolis
Joseph M. Black, Seymour
Kenneth O. Neumann, Lafayette
Eugene S. Rifner, Van Buren
G. O. Larson, LaPorte
Patrick J. V. Corcoran, Evansville

AMA DELEGATES

Donald E. Wood, Indianapolis
Eugene F. Senseny, Fort Wayne
Frank H. Green, Rushville
Jack E. Shields, Brownstown
John S. Farquhar, Jr., Fort Wayne

Fifty-year Club—1970

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Paul P. Bailey, Fort Wayne
Dudley L. Rossiter, Fort Wayne
Hans Sahlmann, Fort Wayne
Nathan L. Salon, Fort Wayne

BOONE COUNTY
Ralph J. Harvey, Zionsville

GREENE COUNTY
Harold B. Turner, Bloomfield

HAMILTON COUNTY
James W. Griffith, Sheridan

JOHNSON COUNTY
William G. Hibbs, Franklin

LAKE COUNTY
Robert N. Bills, Gary
Hedwig S. Kuhn, Munster
Mary Spivack, Gary

MARION COUNTY
Walter P. Morton, Indianapolis
Roy V. Myers, West Palm Beach, Florida
John F. Rigg, North Palm Beach, Florida
Okla W. Sicks, Indianapolis

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William C. Reed, Bloomington

PORTER COUNTY
Clarence M. Harless, Chesterton

RANDOLPH
Leland K. Phipps, Union City

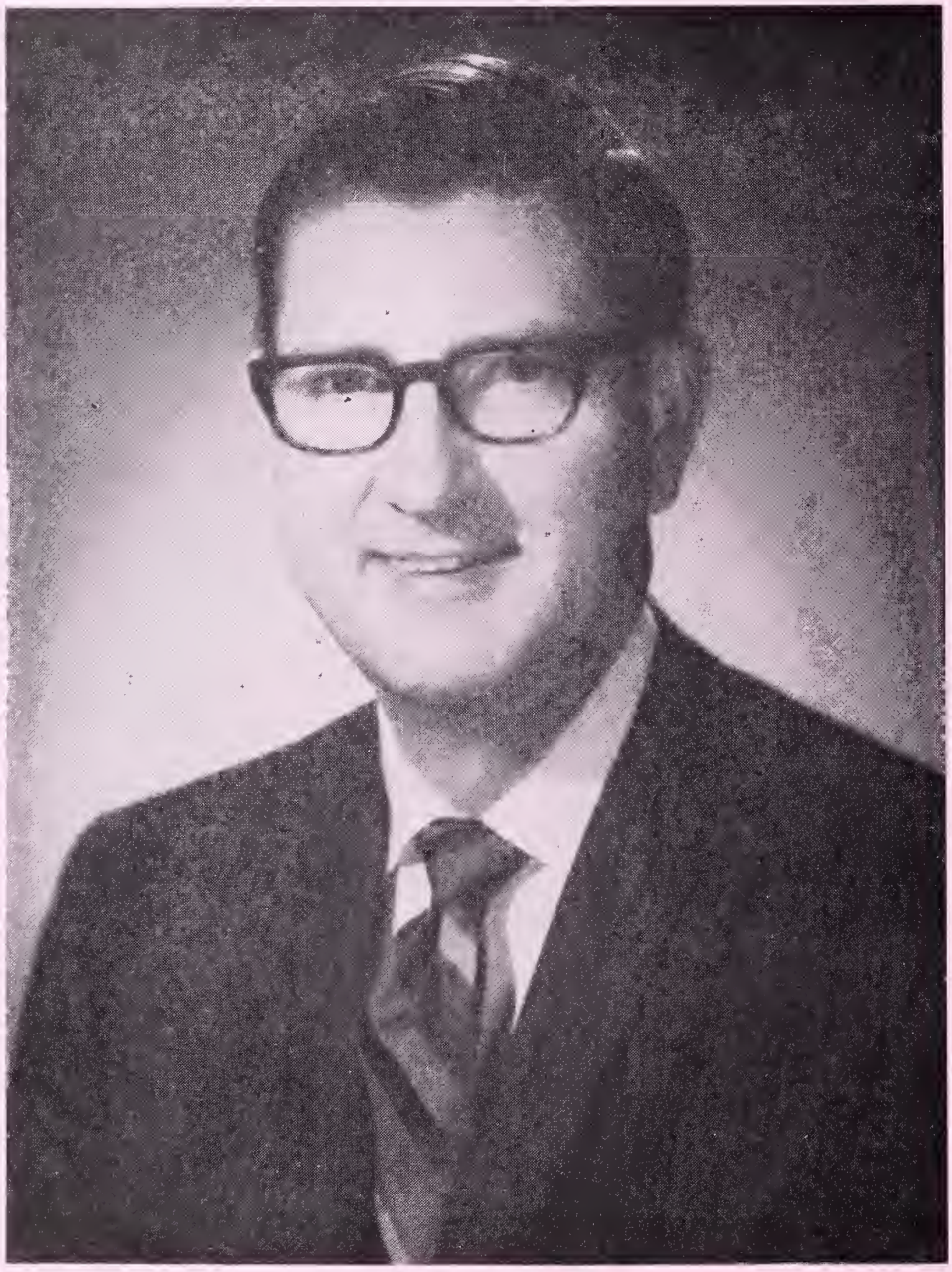
ST. JOSEPH COUNTY
James V. Cassady, South Bend
Kenneth T. Knode, South Bend
Andrew Petrass, South Bend

SULLIVAN COUNTY
John S. Brown, Carlisle

VANDERBURGH COUNTY
Robert R. Acre, Evansville
Harley M. Kauffman, Evansville

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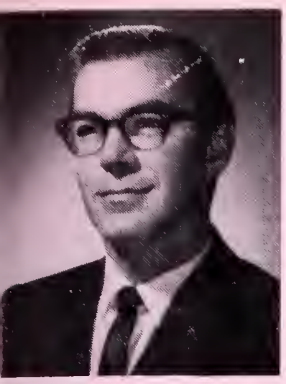


LOWELL H. STEEN, M.D.

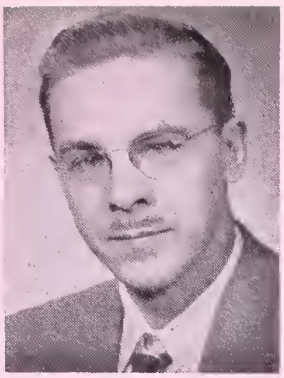
President

Indiana State Medical Association

1969-70



M. O. SCAMAHORN, M.D.
President-Elect
Pittsboro



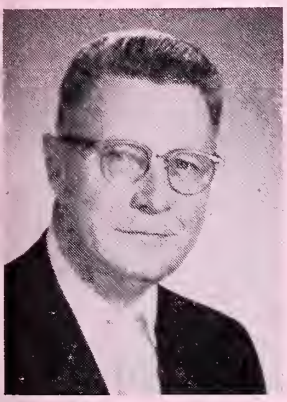
LESTER HOYT, M.D.
Treasurer
Indianapolis



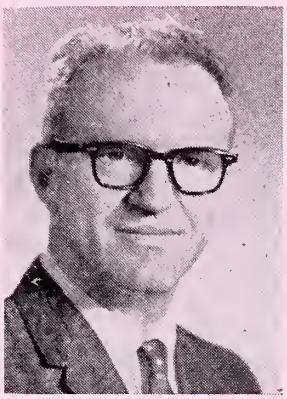
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Chairman of Board
Attica



DONALD M. KERR, M.D.
Chairman
Executive Committee
Bedford



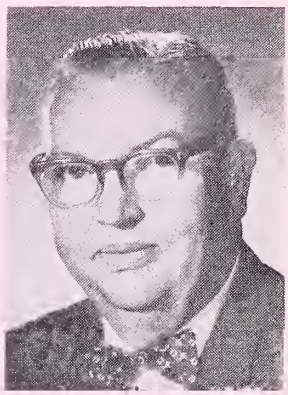
HUGH K. THATCHER, JR., M.D.
Asst. Treasurer
Indianapolis



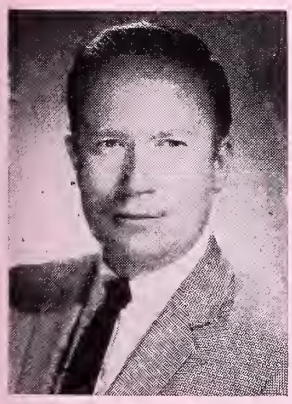
BURTON E. KINTNER, M.D.
Executive Committee
Elkhart



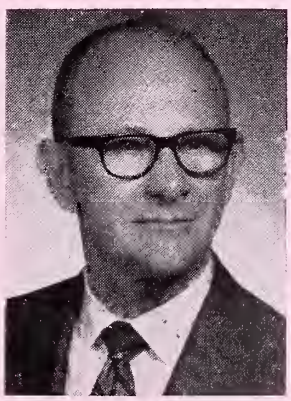
DORIS M. CLOUSE
President, Auxiliary
Evansville



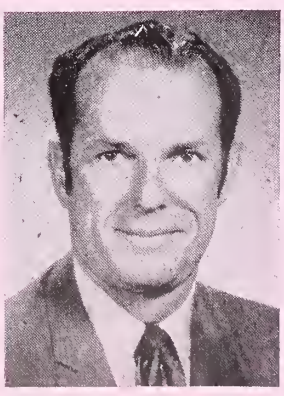
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Executive Secretary
Indianapolis



KENNETH W. BUSH
Administrative Assistant
Indianapolis



ROBERT J. AMICK
Field Secretary
Scottsburg

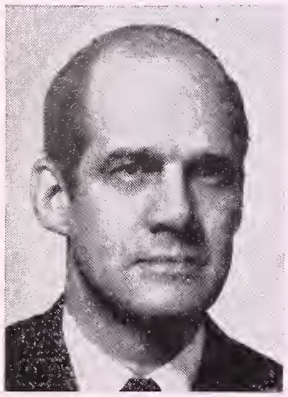


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Field Secretary
Indianapolis

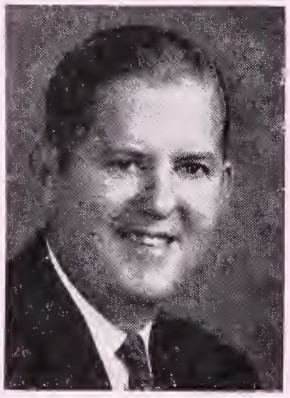


JOHN L. WALTERS
Field Secretary
Kokomo

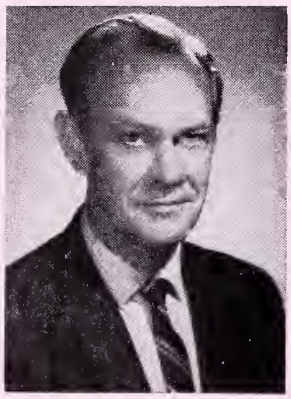
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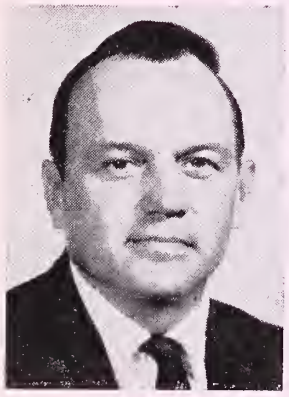
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Bedford



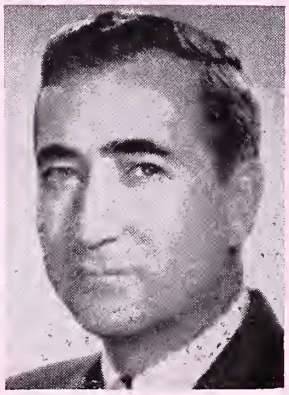
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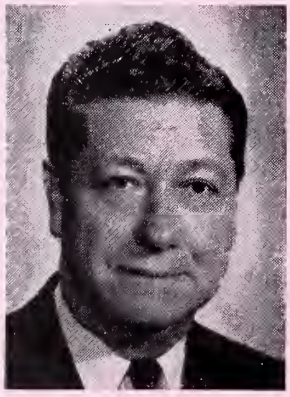
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L. G. MONTGOMERY, M.D.
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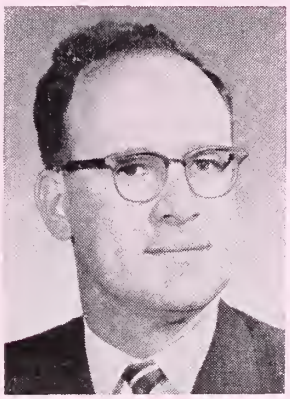
DAVID A. BICKEL, M.D.
Associate Editor
South Bend



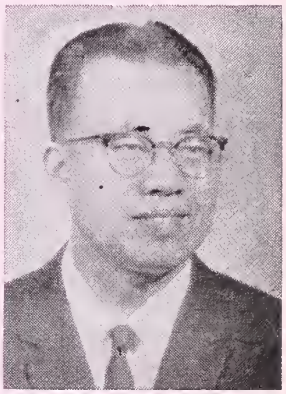
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Indianapolis



ALVIN J. HALEY, M.D.
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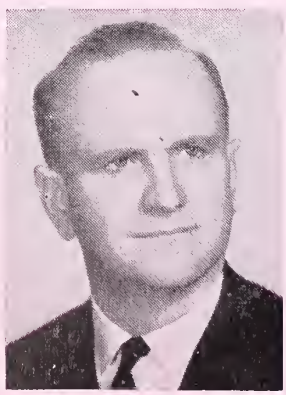
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Editorial Board
Gary



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Editorial Board
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JENE R. BENNETT, M.D.
Editorial Board
South Bend



W. D. SNIVELY, JR., M.D.
Editorial Board
Evansville

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Surgery

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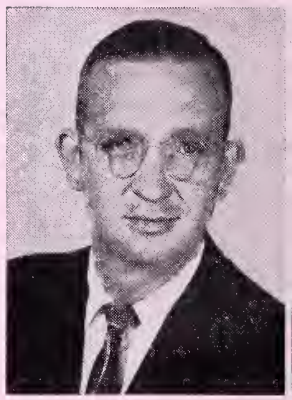
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Washington

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Fort Wayne

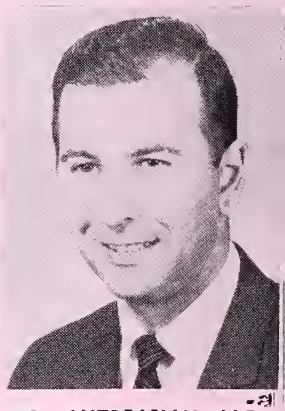
Internal Medicine



EVART M. BECK, M.D.
Indianapolis



D. EDMUND STOREY, M.D.
Indianapolis



BERJ ANTREASIAN, M.D.
Indianapolis

Ophthalmology and Otolaryngology



GEORGE A. CLARK, M.D.
Indianapolis



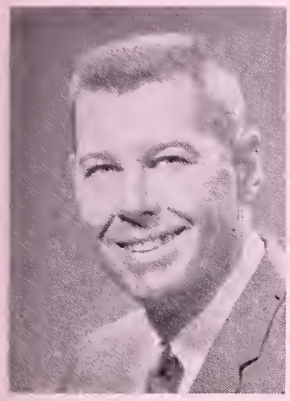
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Goshen



DAVID L. ALVIS, M.D.
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Anesthesiology

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South Bend

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Greenfield

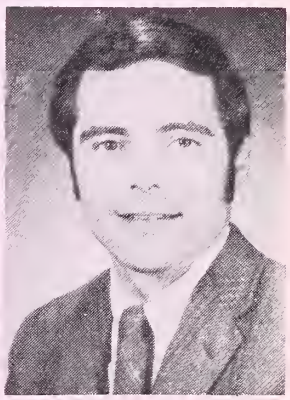
General Practice



WARREN McCLURE, M.D.
Kokomo

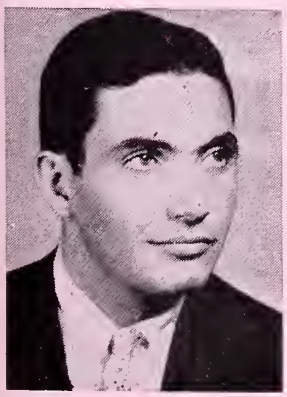


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Greensburg

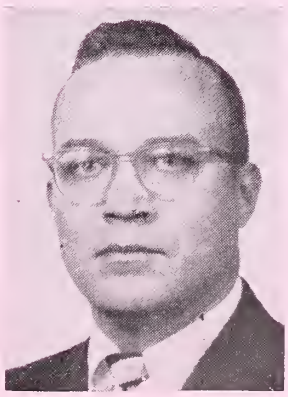


JAMES T. ANDERSON, M.D.
Greenfield

Obstetrics and Gynecology



CHARLES R. ECHT, M.D.
Indianapolis



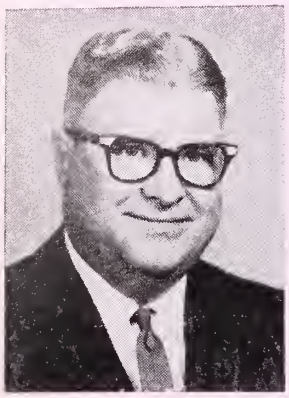
BARTON T. SMITH, M.D.
Marion



JEROME F. DOSS, M.D.
Kokomo

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LESTER L. RENBARGER, M.D.
Marion

VICE-CHAIRMAN



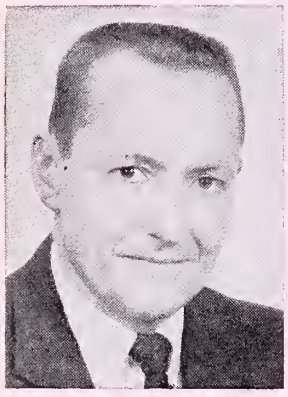
HENRY G. NESTER, M.D.
Indianapolis

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South Bend

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ROBERT E. BECK, M.D.
Evansville



MARVIN N. GOLPER, M.D.
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Elkhart

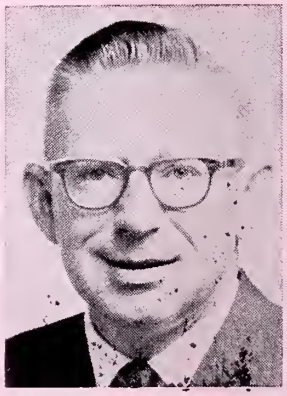
Nervous and Mental Diseases



STANLEY HAMMOND, M.D.
Munster



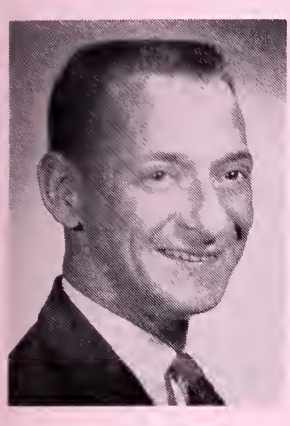
JOHN I. NURNBERGER, M.D.
Indianapolis



WESLEY A. KISSEL, M.D.
Indianapolis

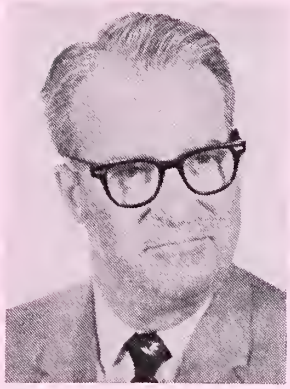
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Indianapolis

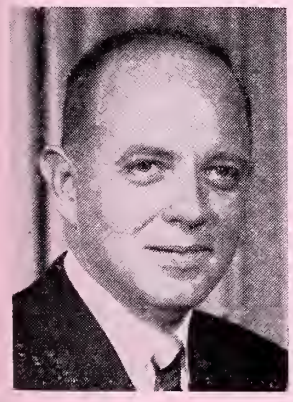


WENDELL E. BROWN, M.D.
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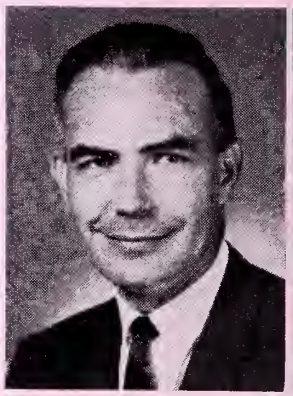
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SCIENTIFIC EXHIBITS: S. O. Waife, Indianapolis, chairman.

WOMEN PHYSICIANS: Agatha Wilhelm, South Bend, chairman.

LOCAL COMMITTEES

Samuel E. Bechtold, South Bend, General Chairman.

HOUSING: George M. Haley, South Bend, chairman; Leslie M. Bodnar, South Bend; Gordon C. Cook, South Bend.

MEN'S GOLF TOURNAMENT: John E. Krueger, South Bend, chairman; and Edson C. Fish, South Bend.

TRAP and SKEET: G. Richard Green, South Bend, chairman, and Philip R. Myers, South Bend.

PUBLICITY: Louis F. Sandock, South Bend, chairman, and John O. Hildebrand, Jr., South Bend.

ENTERTAINMENT: Donald Grillo, South Bend, chairman, and Hansel O. Foley, South Bend.

AUXILIARY and WOMEN'S ACTIVITIES: Mrs. Daniel D. Stiver, South Bend, chairman.

TRANSPORTATION: Mrs. William H. Shriber, South Bend, chairman.

ART and HOBBY SHOW: Mrs. Daniel D. Stiver, chairman; Mrs. Eldred MacDonell, Mrs. Leslie Borough.

Schedule of Events

121st Annual Convention
Indiana State Medical Association
Athletic and Convocation Center
Notre Dame University
South Bend, Indiana

(All Events will be on Eastern Daylight Saving Time)

(The scientific program for the 121st annual convention of the Indiana State Medical Association is acceptable for 12 prescribed hours by the American Academy of General Practice).

Monday, October 12, 1970

12 noon — Executive Committee luncheon meeting, Randall's Inn, 130 Dixie Way S.

2:00 p.m. — Board of Trustees meeting, Randall's Inn.

Monday Evening, October 12, 1970

8:00 p.m. — Annual Trustees dinner, Randall's Inn.

Tuesday Morning, October 13, 1970

8:00 a.m. — Board of Trustees breakfast meeting, Randall's Inn.

8:30 a.m. — Registration begins, Gate 1, Lobby, Athletic and Convocation Center.

8:30 a.m. — Opening of technical and scientific exhibits, Athletic and Convocation Center.

9:00 a.m. — Meeting of House of Delegates, Monogram Room, Athletic and Convocation Center.

11:00 a.m. — Editorial Board meeting, C-127, Athletic and Convocation Center. (Luncheon 12 noon).

11:00 a.m. — Golf Tournament, South Bend Country Club, 25899 Country Club Dr.

11:00 a.m. — Trap and Skeet Shoot, Chain O'Lakes Gun Club, 55950 Country Club Dr.

12 noon — Past Presidents Luncheon, Faculty Lounge, Notre Dame University.

12 noon — Luncheon for Women Physicians of Indiana, home of Agatha Wilhelm, M.D., 1121 Leeper Rd.

Tuesday Afternoon, October 13, 1970

1:30 p.m. — Indiana Bone and Joint Club X-Ray Conference, Indiana Club, 320 W. Jefferson.

(All members of the Indiana State Medical Association are invited to attend).

2:00 p.m. — Reference Committee meetings, Athletic and Convocation Center.

Reference Committee No. 1, C-123.
Reference Committee No. 2, C-124.
Reference Committee No. 3, C-125.
Reference Committee No. 4, C-127.
Reference Committee No. 5, C-129.

5:30 p.m. — Cocktail hour and dinner of the Indiana Bone and Joint Club, Indiana Club, 320 W. Jefferson.

(Members of the Indiana Bone and Joint Club only).

5:30 p.m. — Cocktails and dinner for Golfers and Trap Shooters, South Bend Country Club.



JAMES E. SIMMONS, M.D.
Indianapolis

Professor and Coordinator of Child Psychiatry Services, Indiana University Medical Center; Member of the Board of Directors of the Child Guidance Clinic of Marion County, Inc.; M.D. degree from Ohio State University College of Medicine, 1947.



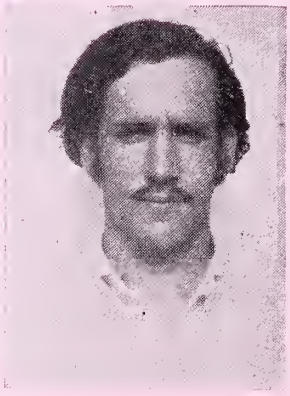
EDWARD C. SENAY, M.D.
Chicago

Assistant Professor of Psychiatry and Chief, Psychiatric Consultation Service, University of Chicago Medical School; Chief of the Section of Clinical Psychopharmacology in the Illinois State Drug Abuse Program; M.D. degree from Yale University School of Medicine, 1956.



SARA C. CHARLES, M.D.
Notre Dame, Ind.

From the Psychological Services Center, University of Notre Dame; Specialist in psychiatry; Consultant to the Loyola University (Chicago) Department of Psychology; M.D. degree from St. Louis University School of Medicine, 1964.



MEL BROWN
Indianapolis

From Gary, Ind.; Presently in combined degree program at Indiana University, Bloomington, in medicine and sociology; Class of 1972, Indiana University School of Medicine.

Fireside Conference

on

YOUTH AND DRUGS

Tuesday, October 13, 1970, 8 p.m.

Monogram Room, Athletic and Convocation Center.

(Wives and guests invited).

JAMES E. SIMMONS, M.D.,
Indianapolis, Moderator

Panelists:

EDWARD SENAY, M.D.,
Chicago, Ill.

SARA C. CHARLES, M.D.,
Notre Dame, Ind.

MEL BROWN, Indianapolis,
(Student)

Wednesday Morning, October 14, 1970

8:00 a.m. Board of Trustees breakfast meeting, Randall's Inn.

8:30 a.m. Registration continues, Athletic and Convocation Center.

8:30 a.m. Opening of technical and scientific exhibits, Athletic and Convocation Center.

8:30 a.m. New Methods and Media for Physician Education, Medical Resources Program of the I.U. School of Medicine, Gym 1-M, Athletic and Convocation Center.

GENERAL MEETING

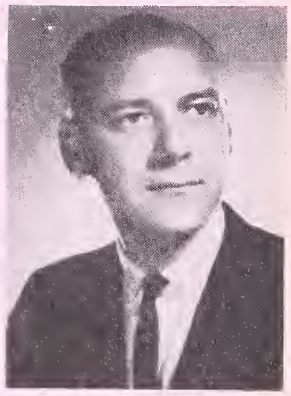
Monogram Room
Athletic and Convocation Center

Call to order by Lowell H. Steen, President, Indiana State Medical Association.

John L. Ferry, M.D., Presiding.

9:00 a.m. *"Evaluation of the Fetus During Labor,"*

RICHARD W. STANDER, M.D., Cincinnati, Ohio.

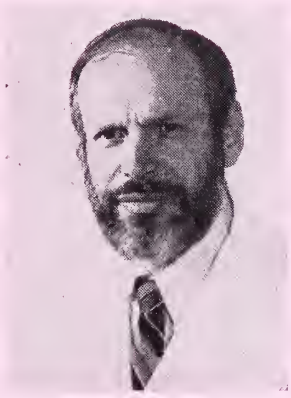


RICHARD W. STANDER, M.D.
Cincinnati, Ohio

George B. Riley Professor of Obstetrics and Gynecology and Chairman, Department of Obstetrics and Gynecology, University of Cincinnati College of Medicine; M.D. degree from the University of Michigan Medical School, 1951.

9:40 a.m. *"Immunization,"*

ELI GOLD, M.D., Cleveland, Ohio.



ELI GOLD, M.D.
Cleveland, Ohio

Professor of Pediatrics, Cleveland Metropolitan General Hospital, Cleveland; Specialist in virology and infectious disease; Chairman of the Committee for Teaching Mechanisms of Infection, Case Western Reserve University; M.D. degree from Case Western Reserve University School of Medicine, 1950.

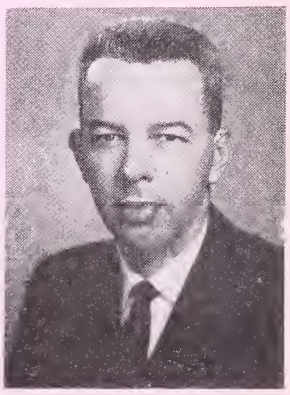
10:20 a.m. Intermission

10:30 a.m. *"The Natural History and Clinical Course of Atherosclerotic Peripheral Arterial Disease,"*

JOHN A. SPITTELL, Jr., M.D., Rochester, Minn.

11:10 a.m. *"Lessons from the Late Results of Peripheral Vascular Surgery,"*

MR. H. H. G. EASTCOTT, M.S., London, England.



JOHN A. SPITTELL, Jr., M.D.
Rochester, Minn.

Associate Professor of Medicine, Mayo Graduate School; Specialist in internal medicine and cardiovascular disease; M.D. degree from the University of Maryland School of Medicine, 1949.

11:50 a.m. Time allowed to view technical and scientific exhibits, Athletic and Convocation Center.

SECTION MEETINGS

12 noon SECTION ON SURGERY luncheon meeting, C-126, Monogram Room A, Athletic and Convocation Center. (Joint meeting with the Indiana Chapter of the American College of Surgeons and the Indiana chapter of the International College of Surgeons).

Election of Section officers for 1971.

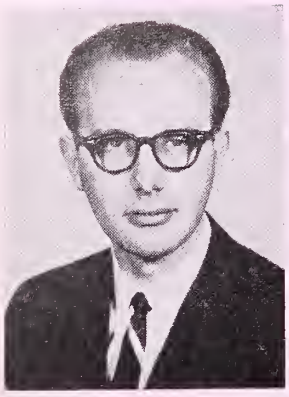
12 noon SECTION ON INTERNAL MEDICINE meeting, C-124, Athletic and Convocation Center. (Business meeting only).

Election of Section officers for 1971.



MR. H. H. G. EASTCOTT, M.S.
London, England

Member of the Court of Examiners, Royal College of Surgeons of England, University of London, Queen's University, Belfast; Surgical Research Fellow, Harvard Medical School and Peter Bent Brigham Hospital; Hunterian Professor, Royal College of Surgeons of England; M.D. degree from St. Mary's Hospital Medical School, 1941.



ALVIN M. LoSASSO, M.D.
Indianapolis

Assistant Professor, Department of Anesthesiology, I.U. Medical Center; Medical Director, Inhalation Therapy Department, I.U. Medical Center; Anesthesiology Consultant, Intensive Care Units, I.U. Medical Center; M.D. degree from the Ohio State University Medical School, 1963.



A. ALAN FISCHER, M.D.
Indianapolis

General practitioner; Member of the AAGP Board of Directors; Chairman of the AAGP Publication Committee; Chairman of the AAGP Committee on Insurance; Former president of the Indiana Academy of General Practice; M.D. degree from the I.U. School of Medicine, 1952.



A. C. OFFUTT, M.D.
Indianapolis

State Health Commissioner; Secretary, Indiana State Board of Health; Specialist in public health; M.D. degree from the Indiana University School of Medicine, 1940.

THE EXHIBITS

We urge you to visit with the exhibitors — they are here to help you — and to bring you the latest information. They contribute to financing your convention.

Wednesday Morning, October 14, 1970

12 noon — SECTION ON ANESTHESIOLOGY luncheon meeting, C-123, Athletic and Convocation Center.

"Long-Term Ventilatory Care of the Intensive Care Patient,"

ALVIN M. LoSASSO, M.D., Indianapolis.

Election of Section officers for 1971.

12 noon — SECTION ON GENERAL PRACTICE luncheon meeting, C-123, Athletic and Convocation Center.

"New Specialty—Family Medicine,"

A. ALAN FISCHER, M.D., Indianapolis.

Election of Section officers for 1971.

12 noon — SECTION ON OBSTETRICS AND GYNECOLOGY luncheon meeting, C-125, Athletic and Convocation Center.

"Coagulation Defects Following Intra-amniotic Installation of Hypertonic Saline,"

RICHARD W. STANDER, M.D., Cincinnati, Ohio.

Election of Section officers for 1971.

12 noon — SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE luncheon meeting, C-127, Athletic and Convocation Center.

"New Developments in Public Health, School Health and Industrial Health,"

ANDREW C. OFFUTT, M.D., Indianapolis.

Election of Section officers for 1971.

12 noon — SECTION ON RADIOLOGY luncheon meeting, C-130, Monogram Room B, Athletic and Convocation Center.

Election of Section officers for 1971.

12 noon — SECTION ON NERVOUS AND MENTAL DISEASES luncheon meeting, Promenade Room A, Athletic and Convocation Center.

"Childhood Behavior and Learning Problems and the Family Doctor,"

JOHN H. YOUNG, M.D., Traverse City, Mich.

Election of Section officers for 1971.

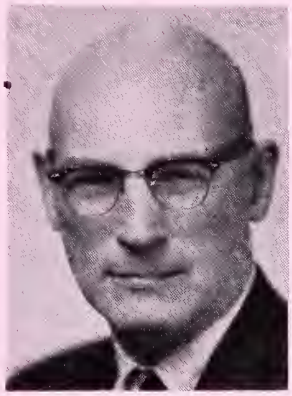


JOHN H. YOUNG, M.D.
Traverse City, Mich.

Director, Northwest Michigan Child Guidance Clinic, Traverse City, Mich.; Diplomate of the American Board of Psychiatry and Neurology; Fellow of the American Psychiatric Association; M.D. degree from Harvard Medical School, 1946.

12 noon — SECTION ON PATHOLOGY AND FORENSIC MEDICINE luncheon meeting, laboratories of the South Bend Medical Foundation, 531 N. Main St.

Election of Section officers for 1971.



RICHARD M. MAGRAW, M.D.
Chicago

Deputy Executive Dean, University of Illinois College of Medicine; Specialist in psychiatry and neurology; Former Assistant Dean, University of Minnesota; Former Deputy Assistant Secretary for Health Manpower, DHEW; M.D. degree from the University of Minnesota Medical School, 1944.

12 noon — SECTION ON PEDIATRICS luncheon meeting, C-129, Athletic and Convocation Center.

ELI GOLD, M.D., Cleveland, Ohio.

Election of Section officers for 1971.

12 noon — SECTION ON DIRECTORS OF MEDICAL EDUCATION luncheon meeting, C-131, Athletic and Convocation Center.

"Current Trends in Medical Education,"

RICHARD MAGRAW, M.D., Chicago, Ill.

Election of Section officers for 1971.



RICHARD H. MOY, M.D.
Springfield, Ill.

Professor of Medicine and Dean of the School of Medicine, Southern Illinois University; Former Director, University Health Services, University of Chicago; M.D. degree from the University of Chicago Medical School, 1957.

12 noon — SECTION ON COLLEGE HEALTH PHYSICIANS luncheon meeting, Promenade Room B, Athletic and Convocation Center.

"The Making of a Doctor,"

RICHARD MOY, M.D., Springfield, Ill.

Election of Section officers for 1971.

12 noon — SECTION ON CUTANEOUS MEDICINE meeting, Promenade Room C, Athletic and Convocation Center. (Business meeting only).

Election of Section officers for 1971.

Wednesday Afternoon, October 14, 1970

1:00 p.m. — Time allowed to view technical and scientific exhibits, Athletic and Convocation Center.

2:00 p.m. — Small County Delegates meeting, Foyer, Monogram Room, Athletic and Convocation Center.

3:00 p.m. to 5:00 p.m. — MEET THE PROFESSOR MEETINGS Monogram Room, Athletic and Convocation Center. (All members of the Indiana State Medical Association are invited to attend).

Participants:

RICHARD W. STANDER, M.D., Cincinnati, Ohio

ELI GOLD, M.D., Cleveland, Ohio

JOHN A. SPITTELL, Jr., M.D., Rochester, Minn.

MR. H. H. G. EASTCOTT, M.S., London, England

5:00 p.m. — Time allowed to view technical and scientific exhibits, Athletic and Convocation Center.

Wednesday Evening, October 14, 1970

8:00 p.m. — Gaslight Party, Indiana Club, 320 W. Jefferson.

Thursday Morning, October 15, 1970

8:00 a.m. — Board of Trustees breakfast meeting, Randall's Inn.

8:30 a.m. — Registration continues, Athletic and Convocation Center.

8:30 a.m. — Opening of technical and scientific exhibits, Athletic and Convocation Center.

8:30 a.m. — New Methods and Media for Physician Education, Medical Resources Program for the I.U. School of Medicine, Gym 1-M, Athletic and Convocation Center.

9:00 a.m. — Active Participation or Self-Evaluation Program, Monogram Room.

(See next page for other Thursday activities at Ramada Inn.)

11:00 a.m. — Reception for members of the Fifty Year Club, Lobby, Gate 10, Athletic and Convocation Center.

12 noon — PRESIDENT'S LUNCHEON, Arena, Athletic and Convocation Center.

Presiding officer: Lowell H. Steen, M.D., President, Indiana State Medical Association.

Invocation: .....

Recognition of Fifty Year Club.

Response: Roy V. Myers, M.D., West Palm Beach, Florida, formerly Indianapolis.

Presentation of Mental Health Award.

Presentation of Public Relations Awards.

Presentation of Community Service Award.

Presentation of Scientific Awards.

Thursday Afternoon, October 15, 1970

2:00 p.m. — Final meeting of the House of Delegates, Monogram Room, Athletic and Convocation Center.

Election of officers.

Meetings of Board of Trustees and Executive Committee immediately following adjournment of House of Delegates.

Thursday Morning, October 15, 1970

(See previous page for other Thursday activities.)

9:00 a.m. JOINT MEETING OF THE AMERICAN COLLEGE OF PHYSICIANS AND THE INDIANA SOCIETY OF INTERNAL MEDICINE, Ramada Inn, 52890 U.S. 31.
(All members of the Indiana State Medical Association and their wives are invited to attend).
Robert L. Rudesill, M.D., F.A.C.P., Indianapolis, Program Chairman

Evart M. Beck, M.D., F.A.C.P., Indianapolis, President, Indiana Society of Internal Medicine, presiding.

9:00 a.m. Introduction of Guests

9:15 a.m. *"Report on Indiana Society of Internal Medicine's Recent Fee Survey,"*

HUGH H. STEELE, M.D., F.A.C.P., Lafayette

9:30 a.m. Panel Discussion—WHAT'S AHEAD IN HEALTH CARE DELIVERY IN THE U.S.A.

JOHN NORRIS, Indianapolis, AFL—CIO—*Labor's Plan*

BERNARD P. HARRISON, Chicago, Director of Legislation, American Medical Association—*AMA's Plan*

CHARLES F. DOWNING, M.D., F.A.C.P., Decatur, Illinois, Trustee, American Society of Internal Medicine—*What the Internist Wants*

EVERETT A. JOHNSON, Ph.D., Administrator, Methodist of Gary, Ind. —*Hospital Plan*

QUESTION PERIOD

RAYMOND H. MURRAY, M.D., F.A.C.P., Indianapolis, Professor of Medicine, Indiana University School of Medicine—*Health Care Centers*

RICHARD C. KILBORN, Indianapolis, President, Mutual Medical Insurance, Inc.—*Blue Cross-Blue Shield Plans*

LOWELL H. STEEN, M.D., F.A.C.P., Hammond, President, Indiana State Medical Association—*Internist's Comments*

QUESTION PERIOD

11:30 a.m. Adjourn

Thursday Afternoon, October 15, 1970

1:30 p.m. Meeting continuing, Ramada Inn, 52890 U. S. 31

Don E. Wood, M.D., F.A.C.P., Indianapolis, Governor, Indiana, presiding.

Kenneth G. Kohlstaedt, M.D., F.A.C.P., Indianapolis, Regent, A.C.P.

Edward C. Rosenow, Jr., M.D., F.A.C.P., Philadelphia, Executive Director, American College of Physicians.

1:45 p.m. *"Medical School Affairs,"*

GLENN W. IRWIN, M.D., F.A.C.P., Indianapolis, Dean, Indiana University School of Medicine.

2:00 p.m. *"The Role of the Internist and Modern Medicine,"*

JAMES O. RITCHEY, M.D., F.A.C.P., Indianapolis

2:30 p.m. *"Cardiopulmonary Disease,"*

WALTER J. DALY, M.D., F.A.C.P., Indianapolis, Chairman, Department of Medicine, Indiana University School of Medicine.

3:00 p.m. DR. MORRIS POLLARD, Director Lobund Laboratory, Notre Dame University.

Tour of Lobund Laboratory.

Auxiliary Program

General Chairman of Women's Activities—Mrs. D. D. Stiver (233-1423)

President of St. Joseph County Medical Auxiliary—Mrs. Raymond E. Nelson (232-2596)

Door Prizes—Mrs. Jene R. Bennett (291-4976)

Hospitality—Mrs. Wallace C. Hill (234-6676)

Publicity—Mrs. John W. Karn (287-6476)

Registration—Mrs. G. Richard Green (288-6744)

Transportation—Mrs. William F. Shriber (272-8802)

Monday, October 12, 1970

1:00 p.m. Golf—Elbel Park Golf Club, 26197 Auten Road
($3.00 Greens Fee)

Mrs. James M. Wilson, Chairman (289-5898)

Tuesday, October 13, 1970

All activities will be at South Bend Country Club, 25899 Country Club Drive (287-3373)

Mrs. O. Norman Forrest, Chairman (234-9808)

9:30 a.m. Registration

Coffee and Rolls

10:30 a.m. Needlework Clinic and exhibit by Mrs. K. T. Knode.

Mrs. Edson Fish, Chairman (272-2266)

12 noon Social Hour and luncheon.

Mrs. George Haley, Chairman (232-1223)

Lowell H. Steen, M.D., Hammond, President, Indiana State Medical Association, guest.
(Price $5.00)

Door prizes

Fashion Show by Heather House

3:00 p.m. Bridge

Tuesday Evening, October 13, 1970

8:00 p.m. FIRESIDE CONFERENCE ON YOUTH AND DRUGS
Monogram Room. Athletic and Convocation Center.

JAMES E. SIMMONS, M.D., Indianapolis, Moderator.

Wednesday, October 14, 1970

9:30 a.m. Registration—School of Nursing Building, Memorial Hospital of South Bend, 120 W. Navarre St. (234-9041)

Mrs. Glen E. Hawkins, Chairman (272-0625)

Coffee and Rolls

Early Bird Prizes

10:00 a.m. Indiana State Medical Auxiliary Board Meeting, Mrs. Paul A. Clouse, President, presiding.

11:45 a.m. Luncheon—Morris Inn, Notre Dame, Ind. (234-0141). (Price $4.00)
Mrs. Stephen R. Phelps, Chairman.

Mrs. Paul A. Clouse, President, Indiana State Medical Auxiliary, guest.

1:30 p.m. Tour of Notre Dame by Professor Robert Leader.

3:00 p.m. Art Gallery
"Contemporary Science & Art; A Case for Compatibility,"

PROFESSOR ROBERT LEADER

4:00 p.m. Tea at Art Gallery—served by students of St. Mary's College.

8:00 p.m. Gaslight Party

11:00 p.m. Buffet

Thursday, October 15, 1970

Morning free for shopping

12:00 noon President's Luncheon, Arena, Athletic and Convocation Center, Notre Dame University.

3:00 p.m. Tour of Lobund Laboratory, arranged by Indiana Chapter of American College of Physicians.

Reports of Officers

Executive Secretary

The executive secretary considers it a privilege to make an annual report to the House of Delegates and to review some of the accomplishments of the association during the past year. This report, while not complete and in detail, we hope will give the membership some idea of the many activities which are carried on through your state association headquarters office.

Your headquarters is responsible for maintaining membership and dues records; conducting the official correspondence; notifying members of meetings; officers of their election; committee and commission members of their appointments and duties and preparing minutes of all official meetings of the association. All methods of communication are utilized to extend the influence and usefulness of the Indiana State Medical Association.

The following highlights some of the more important activities of the office of executive secretary and your headquarters staff.

Actions of the 1969 House of Delegates and Their Disposition

Resolutions:

69-2 Was circularized to all physicians through the publication of the proceedings of the 1969 House of Delegates.

69-3 This resolution intent was discussed by the Executive Committee on their visit to Congress in April of 1970. We understand there may be some remedial action as the result of the current study in certain changes in the Title XVIII and Title XIX programs.

69-4 Was referred to the Commission on Public Health and the commission report to this House contains their recommendations.

69-5 While there has been no specific effort made, the Indiana chapter of Internal Medicine has moved its office facilities into the headquarters building of the association.

69-6 Again nothing specific has been done with implementing this resolution but President Steen will ask the House of Delegates to authorize the creation of an organization of all specialty groups in the state of Indiana.

69-10 This resolution has been referred to the Commission on Legislation and there may be a report available following the September meeting of this commission.

69-11 Referred to the Commission on Public Health. They have made a recommendation to the Commission on Legislation for a change in the law governing TB testing.

69-12 Insured ambulatory diagnostic benefits. Referred to Board of Trustees. Board action was reported to 1970 House through "Board Report 70-A."

69-13 Physician Shortage. Referred to Board of Trustees. Board action was reported to 1970 House through "Board Report 70-E."

69-14 Medical Education. Referred to Board of Trustees. Board action was reported to 1970 House through "Board Report 70-B."

69-15 Delivery of Health Care. Referred to Board of Trustees. Board action was reported to 1970 House through "Board Report 70-E."

69-16 Health Manpower. Plus recommendation of Dr. Steen. Referred to Board of Trustees. Board action was reported to 1970 House through "Board Report 70-C."

69-18 Continuing Medical Education. Referred to Board of Trustees. Board action was reported to 1970 House through "Board Report 70-F."
Dr. Steen's request that county societies show evidence of their attempts to organize programs in continuing medical education—under study by the commission.
Dr. Steen's recommendation that Commission on Medical Education be instructed to develop a curriculum of the programs now available in Indiana and that the curriculum be kept current. Referred to Commission on Medical Education. No action other than announcements of programs offered through the medical school.

69-19 Peer Review. Referred to Board of Trustees. Board plans to take action on a final report at its meeting to be held September 12-13.

69-20 College Health Form. Referred to Board of Trustees. Board action was reported to 1970 House through "Board Report 70-H."

69-21 The resolution, as written, constitutes a change in the Bylaws which has been made under Chapter 3, Section 1, item "n."

69-22 SAMA representation in the House of Delegates. Referred to the Commission on Constitution and Bylaws. Reported to 1970 House through the report of the commission.

69-23 Was adopted by the House having the effect of increasing the dues $10.00 effective January 1, 1970.

69-24 Reporting on Financial Status. Report to 1970 House is made through "Board Report 70-J."

69-25 Resolution on Medical Board Procedures. Not adopted by the House but was referred to the Commission on Legislation. Report of the recommendation for the establishment of Medical Disciplinary Board constitutes action on this resolution, if approved by the Board at their meeting Sept. 12-13.

69-27 Review of Blue Cross-Blue Shield Certificates. Referred to Board of Trustees. Board action—A special Board Committee has been appointed and the Board will probably review their findings at the September meeting of the Board. If the report is ready, it will be labeled "Board Report 70-D."

69-28 Dissemination of Information. Board of Trustees' actions have been done by the headquarters office.

69-29 Responsibilities of Trustees. See reports of trustees.

69-32 This was referred to the legal counsel of the association. He has the matter under consideration and is in the process of preparing a proposed bill which will require compulsory arbitration for the 1971 General Assembly action, if approved by the Board of Trustees.

69-33 As written constitutes a change in the Bylaws and, when adopted, the change was appropriately made.

69-34 This resolution is referred to the Commission on Legislation and a bill will be introduced in the 1971 session.

69-35 District Trustee Representation. Action reported to 1970 House by Commission on Constitution and Bylaws.

69-36 This resolution has been handled by the Board of Trustees and by the Commission on Governmental Medical Services and has resulted in the creation of a Medical Insurance Review Committee comprised of four members of the Blue Shield Board; two members of the Association's Commission on Governmental Medical Services and two

members of the Commission on Medical Economics and Insurance. This committee met for organizational purposes on August 16th and there will soon be an announcement made to all county societies as well as commercial insurance carriers of the creation of this committee.

The basic work has been done in contact with the State Department of Public Welfare and the Blue Shield Plan, administrator for Title XVIII and Title XIX. Complaints which have been received from physicians have been transmitted by these committees to Blue Shield and to the State Department of Welfare and the association has been provided with reports as to the findings on delay for payment.

69-37 Teacher Certification for Health Education. Referred to Board of Trustee. Board action—Referred to Commission on Public Health.

President-elect Steen's recommendation. Study of Medical Disciplinary Board. Copy of law proposed is presented to the 1970 House for action, if approved by the Board. Physician on Indiana State Highway Commission. Referred to Commission on Legislation. No action as yet.

Hoosier Teen Health Happening. Held April 23-24, 1970, with over 3,000 high school pupils in attendance.

Membership

The report of membership is contained in detail in report of the Executive Committee, however we might point out that growth, while it still continues, does reflect a slower pace from the period of July, 1969, to July of 1970.

Total Members	Dec. 31, 1969	Dec. 31,1968
ISMA	4482	4440
AMA	4330	4286
July 31, 1969	July 31, 1970	
4450	4455 + 5	
4301	4291 − 10	

By Districts as of July 31, 1970

District	ISMA + Gain − Loss	AMA + Gain − Loss
1	+6	+7
2	−3	0
3	+2	+1
4	−1	−1
5	+4	+4
6	+10	+9
7	−7	−8
8	+3	+1
9	−6	−8
10	0	−3
11	+3	0
12	+2	−4
13	−8	−8

The component county societies showing the most active operation as far as membership gain and loss are concerned for the period of July, 1969, to July, 1970, are as follows: Gain—Delaware-Blackford and Bartholomew-Brown both tied, showing a gain of 5; Vanderburgh County, 6; Allen County, 7. The largest loss in membership is shown by Marion County with a loss of 6.

Executive Committee

Your Executive Committee has met each month to transact the routine business of your association. The minutes of their meetings are published in *The Journal* for the information of the entire membership. A complete set of their actions has been given to the Reference Committees for their review. A capsulated report of the committee's actions will be found elsewhere in the reports to the House of Delegates.

Board of Trustees

The Board of Trustees has met eight times since the 1969 annual meeting and has two other meetings scheduled prior to the meeting of the 1970 House of Delegates. The next meeting of the Board will be held on September 12-13 and the other on October 12th.

In accordance with the action of the House of Delegates, an abbreviated, quickly read report to the trustees; county society officers; delegates and alternate delegates to ISMA; and delegates and alternate delegates to the American Medical Association have been distributed within two weeks following each meeting of the Board. These follow the formal minutes of the trustee meetings which takes from a month to six weeks to transcribe from the taped proceedings but these are regularly published in *The Journal*. The chairman of the Board has submitted a detailed report to this House and it will be found in *The Journal* and the Delegate's Handbook.

CHAMPUS

Activity in the CHAMPUS Department continues to expand and for the nine months ending July 31, 1970, a total of 13,531 claims have been received. Of this 11,101 have been paid and the difference of 2,430 represents many claims which were not eligible for reimbursement and claims which are in the IBM Department awaiting processing. The total amount paid during this period amounted to $908,478.58.

Field Service

During the year the ISMA added an additional field man to its staff to supplement the field service. He was assigned the northern part of state with Mr. Grindstaff reassigned to the central section of Indiana and Mr. Amick to the southern part of the state.

The field staff continued to call on individual physicians and to attend county medical society meetings, as well as report to members of the ISMA Board of Trustees.

Many problems were referred through the field service to the headquarters office where they were in turn either directly handled by a member of the ISMA headquarters staff or were appropriately referred to the Executive Committee, the Board of Trustees or to a commission.

The field staff additionally assisted in organizing district county medical society meetings. They also participated in staff conferences in the headquarters office throughout the year, for the purpose of administrative direction and to discuss problems in various areas of the state. In many instances the field staff was directed to emphasize certain programs of the commissions or the Board when making contact with the membership.

Following the primary elections, the field staff has been active in contacting all nominees for the Indiana General Assembly. The field staff will be registered as ISMA lobbyists during the forthcoming legislature and will be on constant duty at the State House when the legislature convenes. They will observe all bills dealing with health matters and report directly to the Commission on Legislation which will meet weekly during the session.

In addition, the field staff assists the headquarters staff in all functions of the ISMA. Each man has assignments for Board meetings and other such functions. This year the staff, for example, assisted in helping to manage the Hoosier Teen Health Happening by supervising the large body of students and further assisting in a variety of ways.

Such assignments apply to the conduct of the convention and each field secretary has specific duties in seeing that the convention runs smoothly and effectively.

Hoosier Teen Health Happening

The one program conducted by the Indiana State Medical Association this year which had the greatest public relations

impact was the "Hoosier Teen Health Happening."

The reaction of students, teachers, parents, state officials and officials of other organizations has been an overwhelming response of praise and commendation to the association for this activity.

A voluminous number of letters have been received supporting this evaluation, and the survey forms which were returned to the association demonstrate an overwhelming expression of gratitude to the association.

Follow-up activity has been another gauge of the value of the program through utilization of the audio tapes now being used in the school systems throughout Indiana. In the one month following the event and prior to school closing, more than 250 of the tapes were loaned to schools from the tape library. Many schools have purchased tapes for permanent placement in school libraries.

In addition, the association is now developing 16-millimeter, black and white films on each of the presentations and these are to be publicized for use beginning in the fall of 1970.

The event was broadly publicized through the headquarters which led to reporters, radio and television newsmen on the scene throughout the day and a half hour program interviewing students and program participants alike.

This coverage, of course, was in addition to the live coverage by WFBM-TV, Channel 6, Indianapolis.

The success of the Indiana program has been additionally publicized by the AMA. The officers of the association appeared in a 30-minute closed circuit telecast of the event in Chicago during the AMA convention, and AMA representatives on the scene of the "Happening' are developing interview material and slides from the program which will be utilized as radio and television spot announcements throughout the nation.

Speakers Bureau

The association has organized a speakers bureau of approximately 40 members of the association, who will be available for county society meetings, district society meetings, and meetings of other lay and professional organizations. This can only reflect favorably upon the association's public relations. The bureau is to be publicized to county societies and other lay and professional groups.

Relations with Communications Media—Public Relations—

The headquarters office continues to maintain good relations with the media throughout Indiana by assisting reporters and radio and television newsmen with requests for information. Many stories have appeared in Indiana newspapers favorable to the profession through the assistance given by the headquarters office, and many have not appeared which would have been unfavorable because of factual information provided to reporters through the headquarters office.

On the other hand, many stories which reflect poorly upon the profession emanate from Washington, D.C. sources. An example was this year's Medicaid story originating in Washington which accused many physicians, including five in Indiana, of overcharging for Medicaid cases. A prompt investigation by the headquarters revealed several errors and falsifications in the story and resulted in a story or rebuttal which appeared throughout the state. The president and the executive secretary appeared on several radio and television interviews to offset the allegations in this particular story.

In other activities, the staff of the ISMA wrote the story on Tell City physicians organizing a 24-hour medical service for their community; and it was, subsequently, published in the state editions of *The Indianapolis Star* and some southern Indiana papers. Copies of the story were sent to the AMA for their use and to *The Journal* of ISMA for its use.

Good public relations for the profession continues to be a major concern of the staff of the ISMA, three of whom have had lengthy experience in the newspaper, radio and television fields.

Every event which has good news value is capitalized upon to every extent possible. The "Happening" was an outstanding example of this type of event. "The Tell City Story" was another such event involving physicians doing something noteworthy concerning a community problem. Another event was the Hendricks County Medical Society inviting students, interns and residents to a special meeting to encourage them to consider Hendricks County as a place to practice.

There are many activities of the association which are internal in nature which do not lend themselves particularly to news releases, such as the important malpractice survey of physicians which was conducted by the Commission on Medical Economics and Insurance. As the commission finalizes plans in this area, it could result in story material of newsworthiness because its activities may have certain implications for the public at large who are patients.

Meetings

Planning and deliberations through meetings of the Board of Trustees, the Executive Committee and commissions of the ISMA result in the format for action by the association.

From November, 1969, to July 15, 1970, the association was involved in over 80 meetings. Most of them were held in the headquarters office of the association.

Some of the meetings included in this programming schedule were of the following groups, many of which constituted public relation projects in which the association was involved:

Board of Trustees
Executive Committee
Nearly all of the commissions and committees, of which there are 20
Student American Medical Association
Special meeting of commission chairmen and officers
Indiana Health Council
Indiana Public Health Association
Indiana Society of Association Executives
Indianapolis Public Relations Society
Indiana Chapter—Public Relations Society of America
Indiana Youthpower Conference
Indiana Association Executives Association
Staff meetings
Inter-staff Meetings—Indiana Tuberculosis Association, Indiana State Board of Health
Committees of the Board of Trustees
American Medical Association meetings
AMPAC meeting in Washington
Washington legislative visitations
Planning meetings for Hoosier Teen Health Happening
Joint meeting of Indiana Hospital Association and ISMA
Press conferences
Governor's Advisory Committee on Emergency Medical Services
Convention planning meetings
Congress on Occupational Health
Conference of State Society Mental Health Committees
Congress on Medical Education
Conference on Socio-Economics of Health Care
Conference of state chairmen of Medicine-Religion Committee
Congress on Medical Ethics
Public Affairs Conference
Conference on Voluntary Health Agencies
Conference on Physicians & Schools
Woman's Auxiliary meetings and conferences
Conference on Quackery

Conference of Medical Society Executives

Conference of Senior Medical Executives

SMJAB Conference

Pharmaceutical Manufacturers Association.

10 State Medical Society and Executives Roundtable

AMA Conference on Maternal and Child Care

Seminar on Foundations for Medical Care

AMA Legal Conference

AMA Conference on Health Manpower

AMA Communications Institute

These do not include meetings of the officers and other representatives of the association who met with officials and students of the Indiana University School of Medicine and officials of the State Welfare Department, Blue Shield-Blue Cross, Regional Medical Programs, Comprehensive Health Planning and others. In addition, staff conferences were held almost daily with individuals representing an array of associations and organizations with an equal array of proposals, problems and recommendations.

In all of these and all other activities, the staff of the association is involved as they follow the direction of the officers, the trustees and commission chairmen.

Emergency Medical Services

Emergency medical services have received widespread publicity in Indiana through the activities of the Commission on Emergency Medical Services. Dr. John Farquhar, chairman of this commission, has appeared in numerous radio and television interviews and has precipitated a number of stories on the need for improving such services in Indiana. The program of highway sign markers pointing the way to emergency medical facilities has elicited national attention, with the Illinois State Medical Society and Texas Medical Association showing interest in the project as well as national and state Jaycees.

The Convention

The convention of ISMA continues to be a highlight of publicity activity during the year. The ISMA convention unquestionably produces more inches of space in newspapers, statewide, than any other event in Indiana with the possible exception of the 500 mile race in Indianapolis which, of course, is a month-long extravaganza.

Indiana Physicians on AMA Councils and Committees

Baxter, Neal E., M.D.—Council on Occupational Health; Committee on Aerospace Medicine

Behnke, Roy H., M.D.—Residency Review Committee in Internal Medicine

Booher, Norman R., M.D.—Council on Voluntary Health Agencies

Brown, Frederic W., M.D.—Council on Health Manpower; Residency Review Committee for Orthopedic Surgery

Buchanan, Wallace D., M.D.—Inter-Specialty Committee; Vice-Chairman, American College of Radiology

Egger, Ross L., M.D.—Advisory Committee on Continuing Medical Education

Farquhar, John S., M.D.—Chairman, Emergency Medical Services Committee

Gardiner, Sprague H., M.D.—Committee on Health Care of the Poor; Chairman, Committee on Maternal and Child Care; Alternate Delegate, Section on Obstetrics and Gynecology

Green, Frank H., M.D.—AMA Disability Insurance Claims Review; Committee on Private Practice

Hunter, Charles A., M.D.—Residency Review Committee for Obstetrics-Gynecology

Montgomery, Lall G., M.D.—Delegate, Section on Pathology

Nourse, Myron H., M.D.—Alternate Delegate, Section on Urology; Residency Review Committee for Urology

Owsley, Guy A., M.D.—Chairman, Council on Medical Service; Chairman, Committee on Government Medical Services

Ramsey, Frank B., M.D.—President, State Medical Journal Advertising Bureau

Steen, Lowell H., M.D.—Committee on Community Health Care; Ad Hoc Committee, Council on Medical Services, Medical Foundations

Your secretary is serving his 15th year as secretary-treasurer of the Conference of Presidents and Officers of State Medical Societies. This organization will be known in the future as "A Forum For Medical Affairs Sponsored by Presidents and Officers of State Medical Societies." This group conducts an annual meeting immediately preceding the opening session of the AMA House of Delegates and is the largest attended single meeting held during the AMA annual session, with attendance averaging between twelve and fourteen hundred.

What is Ahead

The year ahead will challenge your headquarters office and its staff to cope realistically with the growing critical issues facing medicine.

While having one of the lowest ratios of staff to membership in the nation—nevertheless your experienced staff core has the capability of furnishing needed support for growing responsibilities and challenges in activities.

The past year has been a busy but successful one. No previous year required more productivity in federal legislation, government relations, association programs, and special demands placed upon your association and staff.

As we look ahead at the fast changing scene, we plan to stand ready to offer the membership additional services, such as services to the specialty groups of our state, county and district societies and the general membership. The decade of the '70's will sorely try the capacity of the association to carry out the wishes and objectives of the membership.

On behalf of our entire staff we are indeed grateful to the Board of Trustees, the officers, the official bodies of your association and to the component county and district societies for the cooperation received and for the opportunity of working in your behalf.

JAMES A. WAGGENER,
Executive Secretary

The Treasurer

Inasmuch as the audit for the fiscal year ending September 30, 1969 has been published in *The Journal* of March, 1970, I will not repeat it with this report. Instead my report will deal with our financial status as of July 31, 1970.

The following is an itemized statement of the funds, including securities, of the association as of July 31, 1970.

SUMMARY OF ALL FUNDS

	Cash	*Investments*	*Total*
General Fund	$37,950.11	$264,478.11	$302,428.22
Journal Fund	1,801.42	—0—	1,802.42
Medical Defense Fund	5,640.42	25,000.00	30,640.42
Building Fund	12,979.49	—0—	12,979.49
Woman's Auxiliary	—0—	5,368.69	5,368.69
Student Loan Fund (old)	1,345.27	17,425.03	18,770.30
Kitchen Fund	—0—	5,841.27	5,841.27
Ethel Gastineau Fund	—0—	24.00	24.00
Dues Account (undistributed)	44.75	—0—	44.72

Payroll Account		
4,516.70	—0—	4,516.70
Total $64,278.16	$318,137.10	$382,415.26

LIABILITIES OF GENERAL FUND

Reserve for operating 1st quarter next fiscal year	$66,702.57
Unearned Income	42,483.96
Reserve Journal operations (1st quarter next fiscal year)	6,028.00
Due AMERF	19,625.00
Due Building Fund	58,391.41
TOTAL	$193,230.94

As of July 31 the income for the General Fund has exeeeeded the budget by $2,076.82. Expenditures for this period have amounted to $258,462.54 which is $8,834.46 less than budgeted for the year. However, we still have two months remaining in the current fiscal year and our average cost of doing business amounts to $25,846.25 per month. If this average holds out for the next two months, we face a deficit for the year of approximately $30,000. The Board has voted that monies due the Building Fund for 1970 not be transferred from the General Fund but be used to wipe out the anticipated deficit in the General Fund.

This past year has seen some expenditures which have not been normal in the past, such as the Teen Health Happening, amounting to $21,849.80 and legal fees on the suit against Blue Cross of $5,000.00.

The executive committee and the Board have regularly reviewed the financial statements and the investment account at each of their meetings and the treasurer has followed the recommendations of these bodies by investing all available cash in short term bills or savings accounts in order to earn as much interest as possible.

The certified audit for the fiscal year including September 30, 1970, will not be completed in time for inclusion in this report but will be published in *The Journal* as soon as possible following receipt.

LESTER H. HOYT, M.D., *Treasurer*

Chairman of the Board

As chairman of the Board during the year 1969-1970, it has been an extreme challenge and a great pleasure to serve the membership of the Indiana State Medical Association.

The major portion of the report of the chairman will be given in the form of the Board of Trustees reports covering the various areas which were charged to the Board of Trustees for activity by the House of Delegates and membership of ISMA, or those items of business which came before the Board during the course of the year which the Board itself felt needed study and action, and which it therefore undertook.

This report is merely a review of the activities of the Board which met and deliberated industriously on many occasions. There were, in fact, by the time of the state meeting in October, 1970, in South Bend, many meeting times for the Board of Trustees, seven of which involved both Saturdays and Sundays—full weekend meetings. Only on two occasions (1) prior to the special meeting of the House of Delegates in March and (2) the midsummer meeting in August, were there only one-day meetings. The amount of material and business handled by the Board of Trustees is overwhelming and you cannot appreciate the effort required until you are involved. The members of the Board (those trustees selected by you to represent you) most certainly do just that. They have done an exceptionally fine job in the past years, especially so in this last year. I want to thank each and every one personally connected with the activities of the Board of Trustees who have helped to make this past year what I believe to be a very successful one.

HIGHLIGHTS OF BOARD ACTIVITIES DURING THE YEAR 1969 THROUGH 1970

1. For the first time in association history, the officers of the association met with the staff following the 1969 convention in an informal exchange of information on programs and plans of the association. This meeting was extremely beneficial for the staff and the officers expressed their appreciation for the candid commentary on many items.
2. A committee was formulated to conduct the Hosier Teen Health Happening, which proved to be one of the outstanding public relations programs which the association has ever undertaken. This has been evident in the overwhelming resultant response to the program by students, teachers, parents, school officials, the communications industry, the medical profession and a large number of additional agencies and individuals all concerned with youth and their problems.
3. The Board endorsed the organization of a Speakers Bureau as recommended by the Commission on Medical Education and Licensure and these names which total 37 will be published in *The Journal* and further circulated to agencies and organizations for their use in programming. The subjects involved offer a broad cross section of material on socio-economic matters as well as scientific and medical material.
4. The Board gave its endorsement to Blue Shield to experiment with a panel concept of health insurance coverage involving medical organization participation with a local industry. The idea was approved contingent upon Blue Shield receiving the cooperation of a county medical society.
5. Medicaid, throughout the year, was of prime concern. The Board endorsed sending a letter to all members of the association advising them that each member had a right to accept or reject the conditions of the Medicaid agreement and further advised each member that before accepting they should fully study the ramifications of the agreement not "only as it applies immediately but as to how it might apply to any extension of government control over the practice of medicine in the foreseeable future . . . ."
6. The Board, after considerable discussion on Medicaid and the impracticability of the program as it is now constituted, expressed the need for developing an alternate plan of a practical nature which would provide health care to the welfare segment of the population. The Board referred this matter to the Commission on Governmental Medical Services.
7. The Board investigated thoroughly the rate proposal for the physicians' program under Blue Cross-Blue Shield, further investigated other insurance carrier proposals and found that the Blue Shield-Blue Cross plan was commensurate, if not better, than other plans.
8. The Board approved and pointed out in its deliberations that any physician may have his fees compared with the usual and customary fees in his area and be told how he rates, above or below, but that it was improper for Blue Shield to supply an individual physician with records of the usual and customary charges of other physicians in his area.
9. The Board approved continued use of Blue Shield staff personnel in assisting county medical societies in organizing and developing comprehensive health planning groups.
10. The Board of Trustees, after long and careful consideration of seating the second trustee from the seventh district, moved to seat him with full privileges and referred the report of the Commission on Constitution and Bylaws to the 1970 House of Delegates

of the association. The commission had reported to the Board that the House of Delegates has been in violation of the ISMA Constitution and Bylaws.

11. Although it was apparent that holding the 1970 convention in South Bend would be a financial loss, the Board, after meeting with representatives of the St. Joseph County Medical Society, moved to hold the meeting in South Bend. As an outgrowth, the chairman of the Board was directed to appoint a committee to prepare a "white paper" outlining the requirements for conventions of the ISMA.
12. Medicaid occupied many hours of discussion by the Board of Trustees during the year. One motion asked that a request be made to the director of the State Department of Public Welfare asking for the names of physicians who were participating in the program. Following long discussion, the Board rejected the motion.
13. The Board moved to extend an invitation to the AMA to hold its 1975 Clinical Convention in Indianapolis.
14. The Board reviewed two resolutions and moved that the first one be presented to the 1970 House of Delegates. The first resolution which was directed toward payments to the 75th percentile in Medicaid cases asks that the Board of Trustees appoint an appropriate commission "or body to study this problem and submit to the next annual meeting recommendations for the formulation of a suitable group to negotiate payments in the future." The second resolution, which was referred to the Commission on Medical Economics and Insurance, dealt with fee structures in view of third-party involvement and asked that a commission study the applicability of the California Relative Value Schedule for Indiana, since many physicians are now using this schedule in formulating their fee structures.
15. The Board again planned to meet with medical school faculty and students sometime in the fall to discuss, informally, matters of mutual concern in the area of medical education.
16. The Board also acted to acquire more information on the activities of the Governor's Commission on Medical Education and sought to define their relationship with this commission.
17. The Board directed that a standardized College Health Record form be formulated. This is being accomplished through the Section on College Health Physicians of the ISMA.
18. A motion to abolish the orientation program as a requirement of membership was adopted and a resolution to this effect was referred to the Commission on Constitution and Bylaws. The resolution further asks that county medical societies establish orientation programs suited to their own needs. At present the Commission on Special Activities is working on projects which would assist county medical societies in accomplishing this.
19. The Board was asked by the Commission on Medical Education and Licensure to endorse elimination of the three-year residency requirement in the state of licensure of foreign medical graduates before being licensed in Indiana. The Board rejected this proposal.
20. The Board also rejected endorsement of another motion by this commission to grant a five-year temporary license to physicians participating in institutional practice.
21. The Board reviewed, periodically, the activities of the Commission on Convention Arrangements and made suggested changes and alterations to the format of the forthcoming convention.
22. In addition, the Board at every meeting heard reports from the association's commissions which, in some instances, were taken for information and in other instances took actions on recommendations of these commissions, a number of which are referred to in this report.
23. The Board, at each meeting, also heard reports from each district trustee of the district's activities.
24. The Board directed Judge Ralph Hamill to continue to pursue the suit against Blue Cross which asked that the plan discontinue the statement in their policies that they provide professional services. Judge Hamill said that he could petition the court to make an entry of a court judgment to the effect that this constitutes the practice of medicine, therefore is objectionable and should not be incorporated in any future policy. Such a decree would have the binding effect of law. Later, Judge Hamill reported that an agreement had been reached with Blue Cross and a judgment was to be signed in the Danville Circuit Court stating that it is illegal for Blue Cross to provide professional medical services. All policies so stating were to be phased out.
25. Construction of a kitchen in the lower level of ISMA, as suggested by and planned by a special committee of the Woman's Auxiliary, was considered by the Board and was disapproved.
26. The Board considered a report from the Commission on Constitution and Bylaws concerning recommended changes on calling special meetings of the House of Delegates. The Board amended the commission report to read, "That no more than ten delegates or 34 members from each of at least three board districts be necessary to call a special meeting of the House of Delegates."
27. The Board also took action to recommend to the 1970 House of Delegates that a "Medical Review Committee" be established to serve in the capacity as consultants to those county medical societies who wished to formulate such committees. These committees are often referred to as "peer" review committees.
28. The Board also spent much time planning for the special House of Delegates meeting which was held on March 15, 1970.
29. In view of much criticism of some Board decisions by the LaGrange County Medical Society, the Board invited the entire society to be the guests of the Board at the next meeting to air their views. No one appeared from the society.
30. Throughout the year the Board kept abreast of many additional matters pertaining to legislation, comprehensive health planning, medical education, licensure problems, Medicaid, Medicare, regional medical programs, affairs of *The Journal* of ISMA, employee and administration problems, paramedical assistants' programs, and an untold number of other issues.
31. Sponsorship of trips abroad by the Indiana State Medical Association was considered by the Board. County society-sponsored trips were leaving the impression through brochures published by the travel agency that ISMA is sponsoring such programs. Past actions of the Board prohibit ISMA participation in such ventures because of legal and other implications. The Board re-adopted the present policy with the stipulation there would be no objection to a county making it known that members of the Indiana State Medical Association were invited to participate in county society-planned and sponsored trips.
32. Board submitted a resolution on the Himler Report to the AMA House of Delegates in Chicago. The Indiana delegation formulated the resolution which stated that an on-going,

ten-member committee of the House, superseding all other existing committees, be elected by the House on a rotating term basis to extract material from the Himler Report, as a continuing program of long-range planning for the AMA.

33. Payment of outpatient diagnostic procedures in the private physician's office was pursued by the Board's Liaison Committee with Blue Cross. A joint meeting planned between Blue Shield and Blue Cross was to discuss this matter which would have the effect, if instituted through Blue Shield, of freeing more hospital beds for patients.

34. Blue Cross field men visiting hospital staffs was eliminated through efforts of the Board's Blue Cross Liaison Committee.

35. Policy for donations to charitable groups was established by the Board. Such contributions must (1) benefit physicians throughout the state, (2) be related to the medical field, and (3) be an activity with worthwhile public relations value to the ISMA.

36. Current financial position of the ISMA was discussed many times. The association is presently operating beyond its current income. In the breakdown of allocations from each member's annual dues, $3.49 is set aside for the building fund reserve. To help meet current expenditures the Board moved that the $3.49 be transferred to the General Fund for operating expenses contingent upon discussions with ISMA accountants.

37. Multitude of American Medical Association reports and resolutions to be introduced at the convention in Denver and Chicago were considered in detail by the Board and the delegates and alternate delegates to the AMA prior to these two meetings.

38. Indiana resolutions concerned with AMA public relations were formulated by the Board prior to Chicago meeting of AMA. PR resolution asked that the AMA adopt a more aggressive attitude in its publicity and PR programs.

39. Development of a 13-member grievance committee to hear complaints of individual physicians in matters pertaining to processing of claims was recommended by the Board. The president and chairman of the Board of ISMA were directed by the Board to investigate the possibility of formulating a committee comprised of Blue Shield Board members from each of the 13 medical society districts.

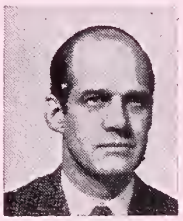
40. Legislation requiring reporting of venereal disease by private laboratories was supported by the Board upon recommendation of the Commission on Public Health. This legislation is to be presented in the forthcoming state legislative session. The Board also approved supporting legislation which would grant funds and authority for local health departments to seek legal opinions on public health matters from local sources, when needed. At present all legal opinions must be provided through the Attorney General's Office of Indiana.

41. Commission on Medical Economics and Insurance's malpractice survey was studied and tabulated. Commission was directed by the Board to study further, and plan to incorporate any such insurance coverage into the insurance package for new members.

42. Regional Medical Programs to come under surveillance of ISMA. The Board moved that a special ad hoc committee be named to investigate RMP programming.

PETER R. PETRICH, M.D., *Chairman*

First Trustee District



GILBERT M. WILHEMUS, M.D.,
Trustee

The annual meeting of the First District Medical Society was held May 7, 1970, at the Rolling Hills Country Club. The meeting was well attended with over 160 members and their wives.

Mead Johnson Company was host for our social hour preceding the dinner. David Hoy, a well known TV personality and night club entertainer, gave an excellent talk and demonstration on extrasensory perception. Dr. George W. Willison, Blue Shield Board member, reported to the group, and Dr. Gilbert M. Wilhelmus reported the past and present business activities of the Indiana State Medical Association. After the meeting the following officers were elected: Fred Smith, M.D., president; Raymond Burnikel, M.D., vice-president; Bernard Rosenblatt, M.D., secretary-treasurer. Dr. Willard Barnhart was elected First District representative on the Blue Shield Board of Directors replacing Dr. George Willison who had completed his terms as a representative. Dr. Ray Newnum was elected alternate trustee for the district.

Medicaid was started this year, and as with all new federal programs, it consumed a considerable portion of our time at several of our medical meetings.

Art Tiernan, the Executive Secretary of the Vanderburgh County Medical Society as well as secretary to the First District, retired this year. The trustee, as well as all the doctors in our district, want to thank Art for a job well done in the past and good luck in the future. The new secretary for our district is Mrs. Carol Rust—the doctors have already recognized her great industriousness and capabilities. The trustee wishes to thank the many members of the district for their cooperation and activity in their local medical societies and participating in the functions of the Indiana State Medical Association.

GILBERT M. WILHELMUS, M.D., *Trustee*

Second Trustee District



JOE DUKES, M.D.
Trustee

The Second District Medical Association held its regular annual meeting at the Elks Country Club in Vincennes on May 28, 1970.

Dr. Thomas O. Barrett of Vincennes, president of the district, presided at the meeting. The program was given by Dr. John A. Galloway of Eli Lilly and Company who spoke on the practical application of insulin and related oral treatment of diabetes.

During the business meeting there was discussion of the Himler report and its opposition was recommended. Also there was discussion of Blue Shield as carrier for Medicaid. It was felt that Blue Shield should withdraw as carrier and legislators of this district should be contacted with the recommendation that welfare administration be returned to the local level.

Following the business meeting a social hour and dinner was served to 54 members and their wives.

Dr. Blazey of Washington invited the district to meet there next year with the Daviess-Martin County Medical Society as hosts.

JOE DUKES, M.D., *Trustee*

Third Trustee District



DONALD M. KERR, M.D., Trustee

After six years as trustee and five as alternate I make my final report to the membership.

The period has been one of more change in medicine, especially in the socio-economic area, than in the entire history of the profession, and it is my opinion that more change is on the way.

We have seen come to pass and had to try to deal with Medicare and Medicaid, each with new problems and new rules for the game (and rules which we did not make but which were thrust upon us by the elected officials of the patients we serve).

It is my opinion, and I have tried to act and vote accordingly, that if I believe in our system of government, I am (and you are) compelled to act within the framework of the legislation passed by our elected officials. I am confident that the vast majority of our membership does not approve of the flagrant lawlessness of our nation's protest groups, but seemingly when the officials of ISMA attempt to work through the maze of government programs on behalf of the membership, a vocal group suggests that we should somehow ignore the reality of the law and present them with a fantasy solution more to their liking—failure to do so brings about more threats of censure resolutions.

I know of no instance where the officers have been given the power to order strikes—and question the value and wisdom if they did. I know of no instance where the officers can, in the manner of union officials, order a member to do or desist from any action in the socio-economic sphere—but somehow we are supposed to negate all the laws and bring happiness to the members.

One of the values of the experience as an officer is the opportunity and the necessity to see beyond the horizons of one's own town and gain an overview of the problems faced in other than our own community. It would be useful to all the members if they could share these experiences and I suspect would alter some of the views and quiet some of the noise of the critics of the leadership. It would certainly make clear the need for the officers to attempt to act for all the members ranging from crossroads towns to megalopolis centers—and the problems and solutions are not the same for both and we are faced always with producing one answer.

I urge the membership to look at the makeup of the Board of Trustees. The majority are generalists and from small communities. By nature and conviction they are not the ultra-liberal dupes of the socializers as charged by some. I know of no leadership group in any organization with a broader base and more representative of all the members. One of the real benefits of the time served as trustee is the chance to know these men who devote much of their time (and therefore money) to working with problems of the membership. They are deserving of praise and commendation—not the ludicrous threats of resolutions of censure which come belching out of an apathetic membership—apathetic, that is, until their noses are tweaked and they fear their purses will be likewise by their elected government officials.

It has been said that the only thing men seem to learn from history is that we don't learn anything from history. I hope the membership will help their officials alter this. Let's not wait to be dragged along by the body politic—let's be in and of it and try to aim it and, hopefully, from inside we can maintain not the status quo, but basic values of our profession in a period of world-wide socio-economic change.

My replacement, Dr. Eli Goodman from Clarksville, brings a good range of experience from within and without the organization. I am confident he will be a thoughtful and thought-provoking member of the Board. I wish him well and urge the membership to give him their support and counsel.

Thanks again.

DONALD M. KERR, M.D., *Trustee*

Fourth Trustee District



ROBERT M. REID, M.D., Trustee

Organized activity in this district was limited this year. Interest in the various activities of the ISMA and the AMA, however, seemed to be increased, if the inquiries directed to the trustee can be used as a guide. Concern was expressed most frequently in matters of malpractice insurance. Comprehensive health planning and possible alternatives to be considered in increasing the supply of physicians in our area.

The district meeting was held in Greensburg on May 13, 1970. The previously discussed increase of $10.00 in district dues was passed. It is hoped that this fund after time of accummulation can be used in bettering communications within the district.

Dr. Walter Able spoke on the "Corporate Practice of Medicine." Dr. Jack Shields was re-elected as alternate trustee. The new district president for the coming year will be Dr. Gordon Fessler.

ROBERT M. REID, M.D., *Trustee*

Fifth Trustee District



WILBERT McINTOSH, M.D., Trustee

The fifth district meeting was held in Greencastle at the Country Club on Wednesday, May 20, 1970. Dr. Tipton, president, presided and Dr. Cleon Schauwecker was secretary. The meeting convened at 4:00 p.m.

Many things were discussed, among them the "Teen Health Happening" which was stated to be a great success. IMPAC was also discussed by Dr. McIntosh, who told the group that much more participation was needed. Mr. Hank Kiszla, representing Blue Shield, made a report on the status of Blue Shield and its relation to Medicaid and Medicare. There was a lengthy discussion on the possibility of levying district dues and a committee was appointed to check the feasibility of hiring a district secretary to serve the district and the component counties. Mr. Amick was present, representing the Indaina State Medical Association, and discussed IMPAC, AMPAC and also the politics of medicine and the place of medicine in politics.

The new officers for the coming year were elected with Dr. William Bannon of Terre Haute unanimously elected as president; Dr. James Cristee was elected unanimously as secretary. Dr. Fred Dierdorf was elected to be the Blue Shield representative from the area.

A tentative date for next year's meeting was set for May 19th and the place to be determined later. It will either be Clay or Vigo County.

I would also like to report briefly on Comprehensive Health Planning status in Indiana. At this time Gary Miller and Fritz Harbridge are continuing to contact counties in Indiana in order to help facilitate their organizing Comprehensive

Health Councils. At this time there are 17 counties already recognized by the Indiana State Board of Health and there are many more who are near completion and will be completed within the near future.

The meeting was adjourned about 6 o'clock and a dinner meeting was held later. The speaker was an attorney from Indianapolis who discussed very thoroughly the possibilities of the corporate practice of medicine and also partnerships in medicine.

Several wives attended the dinner. The meeting as a whole was well attended.

WILBERT McINTOSH, M.D., *Trustee*

Sixth Trustee District



STEPHEN D. SMITH, M.D.,
Trustee

Again it is time for the annual trustees report from along the banks of Little Blue River. We held our annual meeting at Westwood Country Club, New Castle, starting with a golf tourney which lasted into the afternoon. At 2:30 in the afternoon we started our program which consisted of an excellent speech by Dr. Otis Bowen on "The Status of Medicine—State and Nation." This was followed by a speech of the dean of medical school, Glenn Irwin on "Horizons in Education."

We then held a business meeting with re-election of Stephen D. Smith, Knightstown, as trustee and election of Paul Inlow, Shelbyville, alternate trustee. Election of officers for the ensuing year was Dr. David Wynegar, Richmond, president; Dr. Mark Smith, New Castle, vice-president; Dr. John Moenning, Greenfield, secretary-treasurer. The 1971 meeting will be held at Greenfield at Hancock Co. Post in May, 1971.

After the business meeting there was a business meeting of the sixth district A of GP with a report from Dr. Daggy of the recent meeting. This was followed by a great dniner with golf prizes being presented.

After dinner 70 doctors and their wives heard a speech by Senator Roudebush.

I have been quite encouraged and well pleased with the quality of individual medical staff's continuing education programs. It is a shame that the ones that really need this are not availing themselves of it and therefore will probably force some sort of compulsory continuing education control.

STEPHEN D. SMITH, M.D., *Trustee*

Seventh Trustee District



JAMES A. GOSMAN, M.D.,
Trustee

A special meeting of the Seventh District Medical Society held on Nov. 11, 1969, and the annual meeting of the organization, on June 10, 1970, were the principal activities of the society in the last year.

The special meeting, in Indianapolis, called by Dr. Malcolm O. Scamahorn, the president, was held to elect an additional trustee and alternate trustee from the society, offices which had been established with the adoption of a resolution by the House of Delegates of the Indiana State Medical Association in its October 1969, annual meeting.

Dr. Dwight W. Schuster, of Indianapolis, and Dr. Joseph C. Kerlin, of Danville, were elected trustee and alternate trustee, respectively.

Dr. Scamahorn requested an expression from the membership as to whether he should continue as president of the society in view of the fact that he had been elected president-elect of the state association. It was voted that he continue in the office.

At the annual meeting of the society, held at the Ulen Country Club, in Lebanon, Dr. John M. Records, of Franklin, was elected president-elect. He will succeed Dr. Ellery T. Drake, of Martinsville, in 1971. Dr. Donald E. Stephens, of Indianapolis, was elected secretary-treasurer. He succeeds himself.

Among special guests at the meeting were Dr. Peter R. Petrich, of Attica, chairman of the ISMA Board of Trustees; Dr. Glen V. Ryan, of the Blue Shield Board of Directors, and Mr. Richard C. Kilborn, president of Blue Shield, all of whom spoke briefly.

Following a dinner attended by society members and their ladies, Dr. Thomas A. Hanna, medical director of the Indianapolis Motor Speedway, discussed the 500-Mile Race and the medical and safety precautions taken for the event. The meeting and the dinner were preceded by an afternoon of golf.

During the year it was my privilege to have attended meetings of the Hendricks and Johnson county medical societies.

JAMES H. GOSMAN, M.D., *Trustee*

Seventh Trustee District



DWIGHT W. SCHUSTER, M.D.,
Trustee

As a trustee for the seventh district, I have attended all meetings of the Board since my being seated in January, 1970. I also have attended the monthly board meetings of the Marion County Medical Society and one meeting of the Morgan County Medical Society.

With these meetings, as well as individual contacts with members of the four component county societies of the seventh district, I have served as a communication link between the state association and the county societies. This half-year has been a cooperative and satisfactory period, and I look forward to continuing mutually satisfying relationships.

DWIGHT W. SCHUSTER, M.D., *Trustee*

Eighth Trustee District



RICHARD INGRAM, M.D.,
Trustee

The Eighth District Medical Society held its annual meeting June 3, 1970, at Green Hills Country Club, Muncie, Indiana. Guests included Dr. Malcolm Scamahorn, president-elect, ISMA, Mr. Herb Dixon of Indiana Blue Shield, and Mr. Howard Grindstaff of ISMA.

District elections were held and Dr. Eugene Gillum of Portland was elected Eighth District Medical Society president while Dr. William Cripe was elected secretary-treasurer. The alternate district trustee's position previously held by Dr. Paul Sparks of Winchester was filled by the election of Dr. R. D. Williams of Anderson.

The past year has brought changes in medicine and a look at the future—neither of which has been pleasing to the majority of eighth district members. As I have talked to men over the district no doubt the biggest single point of contention that falls within the purview of the ISMA is the proposed inauguration by Indiana Blue Shield of an experimental panel practice plan in a selected Indiana county. I am

sure it is well known that this was one of the major portions of the discussion at the March special meeting of the House of Delegates. While many members of our district were unhappy with the actions of that meeting, at least there was general agreement that such a forum for open discussion of our problems was valuable.

In this, my first year as a trustee, I have become more acutely aware of the forces at work to destroy any vestige of free enterprise in the field of medicine. In my opinion, if we are to have any hope of preserving our system of medicine which has been beneficial to both our patients and ourselves, we must now take these steps:

1) Become active in local, district and state medical affairs.
2) Become active at all levels in the political affairs of our nation.
3) Be willing to have the courage and to make any financial sacrifice necessary to say NO when presented with schemes which we believe will be detrimental to our patients' welfare and, since the welfare of our patients and our own welfare are directly proportional, ultimately detrimental to our own welfare.

RICHARD G. INGRAM, M.D., *Trustee*

Ninth Trustee District



PETER R. PETRICH, M.D., Trustee

The Ninth District Medical Society met in March of 1970 and in June of 1970. The first meeting took place in Lafayette, Indiana, and was a meeting of the delegates and trustees with the purpose of discussing some changes in the structure of the district society and to perhaps give better direction to its activities.

The June meeting took place with the Montgomery County Medical Society as the host at the country club in Crawfordsville. It was an excellent turn out with the scientific session in the afternoon which was attended by approximately 30 physicians. The evening affair was very well attended with an excess of 100 persons in attendance. A very fine program, all in all, and the activities of the district were certainly enhanced by this sort of a get-together.

The important piece of business for the district was that the delegates to the district meeting voted for an increase in dues structure from $1 to $3 for the society membership. Dr. William Sholty was elected to succeed Dr. Petrich as ninth district trustee and Dr. Barton Bridge was re-elected to represent the district on the Blue Shield board.

PETER R. PETRICH, M.D., *Trustee*

Tenth Trustee District



VINCENT J. SANTARE, M.D., Trustee

The tenth district meetings this past year were the most unusual and best attended in several years.

The first meeting held was on September 24, 1969. An overflow crowd attended this meeting presided over by Dr. Ray Doherty, tenth district president. During dinner, an election of district officers was held, resulting in the election of Dr. Robert Milos, president, and Dr. J. M. Siekierski, secretary.

Attendance at this affair was directed to fathers and their sons or daughters, and featured Johnnie Latner, Notre Dame All American Heisman and Maxwell Trophy winner and Pittsburg Steeler star. Mr. Latner was introduced by Dr. Joseph Kopcha, president of the Lake County Medical Society and former Chicago Bear star. Mr. Latner made an unusually interesting talk about professional football and showed an excellent film on the 1968-69 season of the Chicago Bears.

The second meeting was held May 13, 1970 at the Phil Smidt Restaurant. Presiding at dinner was Dr. R. Milos, president tenth district, who introduced Dr. Santare to approximately 120 doctors and their wives.

Dr. Santare stated he would not give the tenth district report at this meeting to save time for the program, but he briefly outlined some of the events that were taking place in the state. Dr. Santare then introduced T. C. Tyrrell, alt. AMA delegate; Herb Dixon, V. P., Blue Shield, the future assistant executive director, Ed Mesterharm, and the tenth district secretary, Dr. J. Siekierski. The minutes of the October meeting were approved. Dr. Siekierski greeted the membership and said a few words as district secretary.

Dr. Milos then introduced Dr. L. W. Neal, president of L.C.M.S. Dr. Neal congratulated the Intrav Agency for conducting such a well-organized trip for the membership, and said he hoped to have future trips with Intrav as everyone was so well pleased with the way they handled all the arrangements.

There was no further business, so Dr. Neal then introduced his brother, Victor Neal of Oregon State University. Mr. Neal presented a very interesting program on oceanography and showed slides of this very fascinating science. Following a question and answer period by Mr. Neal, the meeting was again turned over to Dr. Milos, who thanked Mr. Neal for an enjoyable and informative evening for all.

Your district trustee has made regular monthly reports of state association affairs at the societies in the district, and this has proven to be of considerable value to the county societies.

V. J. SANTARE, M.D., *Trustee*

Eleventh Trustee District



LOWELL J. HILLIS, M.D., Trustee

The 1969 meeting of the Eleventh Trustee District was held at Emly's Restaurant, Marion, Indiana, September 17, 1969.

The business of the district was conducted in the afternoon session and the new officers elected were: president—Dr. Julius Steffen; secretary-treasurer—Dr. Fred Poehler, re-elected. Dr. Lowell J. Hillis of Logansport was re-elected to his second term of office as trustee of this district.

The program was outstanding. The speakers were all from the military service and their subjects were space medicine and undersea medicine. These talks were well received and there was considerable discussion among the membership concerning the program. The attendance at this meeting was excellent, this probably being one of the best attended meetings in the recent years.

The next meeting of the Eleventh Trustee District will be September 23, 1970, at the Holiday Inn in Wabash, Indiana. Another excellent program has been planned for this meeting.

Various county activities in this district have again been known as largely associated with comprehensive health planning. Cass county is progressing very well, especially in the planning of health facilities. The committee on health facilities of our comprehensive health group has been very active in projecting facilities for at least the next ten years.

Your trustee has attended several fine meetings within the district, especially

those held in Wabash and Miami counties. Many discussions have been had investigating methods of invigorating and increasing the interest and attendance at all local meetings of organized medicine.

Again it may be said that most of the activities in this district may be described as "business as usual."

LOWELL J. HILLIS, M.D., *Trustee*

Twelfth Trustee District



WILLIAM R. CLARK, SR., M.D.,
Trustee

During the past three years, as I reported in my previous reports to the ISMA annual meeting, the district has been going through reorganization. I can say with real satisfaction that it has begun to pay off. We had four meetings of the new board of directors, not including the annual meeting held in May. The attendance at these meetings can be improved upon. However, at the annual meeting, over 80 members were in attendance.

I believe that more interest in organized medicine has taken real roots and that real concern for the future welfare of our profession is being manifested. This statement is proven by the fact that seven of my eight counties responded *promptly* to a letter I sent out asking for the names of their new officers and for the names of physicians who would volunteer their services to the various state committees and commissions. Definitely more interest has been shown in the Board of Trustees and the various county meetings I attended. This is really healthy.

Our annual meeting was held on May 20th at the Chamber of Commerce in Ft. Wayne. The following guests were present: Malcolm Scamahorn, M.D., president-elect of the ISMA; Peter R. Petrich, M.D., ninth district trustee and chairman of the Board; Otis Bowen, M.D., thirteenth district trustee; Mr. John Walters, field service, ISMA; Congressman Richard L. Roudebush, Fifth District State Representative and Congressman E. Ross Adair, Fourth District State Representative.

John Hartman, M.D., president of the twelfth district, presided. New officers named were: George C. Manning, M.D., Ft. Wayne, president; Franklin A. Bryan, M.D., Ft. Wayne, vice-president; W. Bradley Hughes, M.D., Waterloo, secretary-treasurer; William R. Clark, Sr., M.D., Ft. Wayne, re-elected trustee; Kenneth F. Iseuogle, elected twelfth district representative to the Indiana Blue Shield board of directors.

That evening we were treated to a talk by Congressman Richard L. Roudebush, principal speaker, on "Happenings in Washington" and Congressman E. Ross Adair on "Why We Are In Cambodia." Both talks were excellent and informative. I am sure every member and guest will long remember their remarks.

I want to thank the outgoing officers for their leadership and co-operation during the past year and my thanks to Dr. Fred Schoen, my alternate. I especially want to thank my counties for their increased interest and their co-operation.

I, as your trustee, along with the new officers and board of directors of the twelfth district, look forward to the combat we must face in the future to moderate change and effectively make the future of our profession respected and restored to the high principles we have experienced in the past.

WILLIAM R. CLARK, SR., M.D.,
Trustee

Thirteenth Trustee District



OTIS R. BOWEN, M.D.,
Trustee

The physicians and various county medical societies were very busy and active this past year. Last September 17, 1969, the district meeting was held at the Morris Inn at Notre Dame. The attendance, although disappointing, was still perhaps a little bigger than average. The afternoon program was stimulating and provocative, the social hour was delightful, and the evening's banquet and entertainment was exceptionally good. The speaker, Mr. Ray Stanish, was a professional one and talked very entertainingly and very authoritatively on the subject of atomic energy. He explained atomic energy in simple terms and thus entitled his talk, "Atomic Energy—Peasant Style."

The 1970 meeting is scheduled for September 3rd at Elkhart. Plans are being made at the present time for an outstanding program. Attempts to stimulate attendance are also being planned.

Marshall County Medical Society has completed a year of outstanding monthly educational meetings. Dr. Stoller has been the organizer for this upsurge of regular informative sessions. Each has been preceded with a dinner. Members of adjacent county medical societies have been invited and have responded quite well in attending.

The St. Joseph County Medical Society has been busily occupied with committee work in preparation for the 1970 Indiana State Medical Association's meeting to be held in South Bend. Preliminary activities point to an outstanding meeting in October for all physicians of the state.

A survey is being conducted by the district's trustee among the membership of the five smaller counties to determine if the previously heard numerous suggestions for a merger were strong enough to warrant such a step. A questionnaire was prepared and mailed to every physician in Fulton, Marshall, Pulaski, Kosciusko and Starke counties to reflect the views of each physician. To date, the response has been about 50% in spite of the fact the questionnaire would take but 30 seconds to complete. Follow-up will be done. No conclusions can be reached yet.

OTIS R. BOWEN, M.D., *Trustee*

Editor of The Journal

Advertising revenue is a little below that of previous years but adjustments in the size of the issues will enable *The Journal* to live within its budget.

This year, for the first time, the Roster issue carried a specialty designation for each member. This was an expensive changeover, since the entire county society portion of the roster was reset. In the future the type for the Roster will be reset only for new additions and changes, and the added expense will not recur.

In addition to the customary special issues on the Heart and Circulatory System, on Malignancy, and for General Practice and the Annual Convention, special stories were carried on the Katherine Hamilton Mental Health Center in Terre Haute and the new Indiana University Hospital in Indianapolis, and an issue in honor of Dr. Goethe Link was published in July.

A special readership interest study was conducted this year. Reader interest in nine state medical journals, of which *The Journal* was one, was measured in relation to 13 major nationally-circulated magazines and journals. The state journals scored very well, and were either second or third in preference among the 14 publications. This will undoubtedly enhance our standing in the advertising world.

The scientific content continues to be well supported by many contributors.

FRANK B. RAMSEY, M.D.,
Editor

Delegates to AMA

Indiana's full contingent of delegates and alternate delegates attended the 121st annual convention of the American Medical Association, June 21 through 25 in Chicago.

Accompanying the delegation were Drs. Lowell H. Steen, Hammond, president; Malcolm O. Scamahorn, Pittsboro, president-elect and Peter R. Petrich, Attica, chairman of the Board.

The delegation chaired by Dr. Eugene F. Senseny, Fort Wayne, reviewed all of the advance material distributed prior to the meeting and met every morning during the five-day session at breakfast to consider late resolutions introduced to the AMA House, as well as plan voting strategy on many of the major issues. The delegation also met at noon each day to continue deliberations.

All four AMA presidential candidates met with the Indiana delegation prior to the Thursday morning elections as well as candidates for other offices of the AMA including the Board of Trustees. Under the circumstances the Indiana group had an excellent opportunity to hear each candidate's personal platform.

A former president of the Indiana State Medical Association, Dr. Guy A. Owsley, Hartford City, was elected chairman of the important AMA Council on Medical Service during the session.

Indiana's delegation included Drs. Don E. Wood, Indianapolis; Frank H. Green, Rushville; Jack E. Shields, Brownstown; John S. Farquhar, Fort Wayne, and Eugene F. Senseny, Fort Wayne.

Alternate delegates included Drs. James A. Harshman, Kokomo; Eugene S. Rifner, Van Buren; Kenneth O. Neumann, Lafayette; Patrick J. V. Corcoran, Evansville; and Thomas C. Tyrrell, Hammond.

Also on hand to meet with the delegation throughout the week were Drs. Sprague H. Gardiner, Indianapolis delegate from the AMA Section on Obstetrics and Gynecology; Lall H. Montgomery, Muncie, delegate from the AMA Section on Pathology and Physiology and Myron H. Nourse, Indianapolis, alternate delegate from the AMA Section on Urology.

Indiana's delegation introduced two resolutions to the House of Delegates: one asked for a more aggressive AMA attitude in its communications and public relations programs while the other asked that the Himler Report be referred to a new Committee on Planning and Development for continuous evaluation as a part of long-range planning for the AMA.

The communications resolution was referred to the Board of Trustees of the AMA.

Concerning the Himler Report and long-range planning and development, the Indiana resolution asked that the committtee be a committee of the House, constituted of nine members of the House and one AMA trustee.

Indiana's resolution and others on the same subject caused one of the longest debates of the House with the final recommendation including a nine-member council made up of four appointed by the speaker of the House (two from the House and two from the membership at large); four appointed by the AMA Board of Trustees (two members of the Board and two members from the membership at large). The ninth member is to be appointed by the president of the Student American Medical Association.

Some of the other Indiana officers in attendance at the meeting were Drs. Burton E. Kintner, Elkhart, member of ISMA Executive Committee; Lester B. Hoyt, treasurer, and Hugh K. Thatcher, assistant treasurer of the association, both of Indianapolis; Lowell H. Hillis, Logansport, ISMA trustee; Dwight W. Schuster, Indianapolis, ISMA trustee; Frederic L. Schoen, Fort Wayne, alternate trustee and G. Beach Gattman, Elkhart, alternate trustee.

In its first uninterrupted Annual Convention since 1967 (thanks to the most elaborate security precautions ever taken), the House of Delegates considered a record volume of business; passed a hotly debated statement on abortion; raised membership dues to help finance needed programs; heard outgoing president Gerald D. Dorman challenge the association to attain and maintain a specific minimum health standard of "a healthy child and a healthy mother;" and applauded newly inaugurated president Walter C. Bornemeier's call for greater emphasis on patient care through an overhaul of medical education and training.

Elections

Wesley W. Hall, Nevada, was elected president elect, defeating two other trustees and one delegate running for the position. Dr. Hall will become the 126th president of the AMA in June, 1971.

H. Thomas McGuire, Delaware, was elected vice president and Russell B. Roth, Pennsylvania, and J. Frank Walker, Georgia, were unanimously re-elected to their posts as speaker and vice speaker of the House, respectively.

John H. Budd, Ohio; Richard E. Palmer, Virginia; James H. Sammons, Texas; and Kenneth C. Sawyer, Colorado, were elected to fill the four vacancies on the Board of Trustees.

George W. Petznick, Ohio, was re-elected to the Judicial Council.

M. Louise C. Gloeckner, Pennsylvania, was elected to the Council on Constitution and Bylaws.

Warren L. Bostick, California, and Bernard J. Pisani, New York, were elected; and Bland W. Cannon, Tennessee, was re-elected to the Council on Medical Education.

Paul W. Burleson, Alabama, was elected; and Donald R. Hayes, Massachusetts, and W. B. Hildebrand, Wisconsin, were re-elected to the Council on Medical Service.

Final Report and Inaugural Address

In his final report to the House, Gerald D. Dorman reminded the profession that "We expect to be recognized and accepted as the leaders of medical and health care planning and action . . . because our experience has made us the best qualified to give leadership in medical care. But if we are to continue in that position, we must earn it. We must deserve it, not because of reputation or tradition, but because of visible achievement . . . ."

After repeating his hope (first stated in Denver) that the 1970's would be the Significant Seventies in medical and health care, Dr. Dorman said, "I should like to set a specific minimum health standard for the American Medical Association to attain and maintain. That is a healthy child and a healthy mother. This does not require a resolution of this House; it does not require legislation or funding. It only requires personal dedication and commitment.

"Already this is being carried out in many places that I know of, and surely in many that I do not. Already the infant and maternal death rates are falling, but I speak also of infant and maternal morbidity. There are lives of mothers and of children permanently damaged for lack of proper care. This is not necessarily a fault of organized medicine because poverty, ignorance, malnutrition and bad sanitation take their toll. These we, as crusading citizens, must overcome now, as leaders in our drive for a healthy child and a healthy mother . . . .

"I want to see all our physicians—our obstetricians and gynecologists, our pediatricians, our general practitioners, our internists and other specialists—renew their contact with the rest of the health team and rededicate themselves to this minimum health standard . . . throughout our population."

Walter C. Bornemeier, in his inaugural address as the AMA's 125th president, cited five areas for improvement in medical education and training: shortening the medical school curriculum; modernizing and shortening residency programs; relating more

medical training to patient care at an earlier point; assimilating full-time teachers into patient care; and reducing the number of medical research institutions and researchers.

"In any new graduate program, we might be advised to emphasize again a preceptorship method of training," he said. "If M.D. graduates could be trained in the active practice of medicine outside the hospital with a physician or group approved for teaching, the doctor shortage would in large measure be solved." He pointed out that such training would emphasize what makes people sick as well as how to make them well again.

Those changes would allow the physician to undertake more rapidly the responsibility "commensurate with his skills and knowledge" and might "overnight add 50,000 doctors to the care of patients in our communities."

Dr. Bornemeier praised medical schools for moving in the right direction. He advocated a goal of six years from high school to the M.D. degree and added that in some schools, first-year students can go directly into a patient-oriented curriculum because "the conventional freshman year in medicine is being given as the final year" of pre-med schooling.

The president said there are now some 35,000 M.D.s in residencies who, 25 years ago, would already have been in active practice. Another 5,000 physicians have quit practice to assume positions as medical educators in hospital residency training programs. And another 10,000 to 12,000 M.D.s are full-time educators in medical schools, a function that 25 years ago "was done by those of us in practice."

The House heard other brief speeches from the president of the National Medical Association; the chairman of the AMPAC Board; and the president of SAMA.

House Actions

From June 21 through June 25, the House was in business sessions for 17 hours and 15 minutes, during which it considered a record 201 items of business. Included were 61 reports — 31 from the Board; three from the Judicial Council; six from the Council on Constitution and Bylaws; 10 from the Council on Medical Education; five from the Council on Medical Service; and six special reports. It also dealt with 140 resolutions — eight un-numbered memorial or commendatory ones; 27 special ones generated by the (Himler) Committee on Planning and Development; and 105 from regular sources.

Abortion: After long debate before the reference committee and on the floor of the House, delegates adopted the following statement on abortion:

"Whereas, abortion, like any other medical procedure, should not be performed when contrary to the best interests of the patient since good medical practice requires due consideration for the patient's welfare and not mere acquiescence to the patient's demands; and

"Whereas, the standards of sound clinical judgment, which, together with informed patient consent should be determinative according to the merits of each individual case; therefore be it

"Resolved, that abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in an accredited hospital acting only in conformance with standards of good medical practice, and after consultation with two other physicians chosen because of their professional competence, and within the Medical Practice Act of his state; and be it further

"Resolved, that no physician or other professional personnel shall be compelled to perform any act which violates his good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional personnel withdraw from the case so long as the withdrawal is consistent with good medical practice."

Consumer Forum: For the first time in its history, the House appointed a special reference committee to hold a public forum, at which individuals and representatives of groups could present their views of medical and health care. The committee heard three hours of testimony on the opening day of the convention. From its report, the House adopted the following recommendations:

"That consideration be given by the Board of Trustees to the creation of a multi-ethnic advisory committee on health care problems of minority groups.

"That the House of Delegates reaffirm its policy of encouraging physicians, as well as paramedical personnel, to continue to provide compassionate and sympathetic care to all patients.

"That the House of Delegates reaffirm Resolution 62, Annual Convention 1969, which states in part: 'It is a basic right of every citizen to have available to him adequate health care' . . . and that 'the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person.'

"That the AMA Advisory Committee on Health Care of the American People be invited to participate in reference committee hearings" of this type if they are held in the future. Consideration of having such an open forum at each AMA convention was referred to the Board of Trustees.

Dues Increase: Until this convention, the amount of AMA dues was prescribed by the Board, for adoption or rejection by the House. On Tuesday, however, the House amended the bylaws to give itself that responsibility. Chapter III, Section 1 (A) of the bylaws now reads:

"(A) How Prescribed - Annual dues for any year shall be prescribed in an amount fixed and determined by the House of Delegates. The Board of Trustees may submit recommendations to the House on the fiscal needs of the association and the level of dues. Dues fixed by the House shall remain in effect until changed."

In response to Board Reports A and B (financial statement of the AMA, and background detail on the need for an increase), the House voted to increase annual AMA dues by $40, to $110. At the same time, the House directed that "basic and explicit information supporting the need for this dues increase, and future dues increases, be promptly disseminated by the AMA to individual members by every reasonable and available means possible; and that the aid of constituent state associations be enlisted in this effort."

The new dues will become effective with the next fiscal year, beginning December 1, 1970.

Recommendations

That the AMA reaffirm, as a statement of the primary purpose and responsibility of the association and the medical profession, "the promotion of the art and science of medicine and the betterment of public health," and, as part of this purpose, apply all possible effort to make medical service of high quality available to all individuals.

That the association has the duty to guide and assist the medical profession in the attainment of this objective.

That the American Medical Association recognize the need for multiple methods of delivering medical services, and that it encourage and participate in efforts to develop them.

That, in the interest of attracting the most highly qualified candidates to the field of medicine, it simultaneously make every effort to maintain and create incentives in medical practice. Among these incentives are a multiplicity of practice options, maximum professional independence and freedom of choice for both physicians and patients.

Health is a state of physical and mental well-being.

That the AMA expand its active role in

planning and developing programs for medical care in all of its ramifications and that it encourage and assist state and county medical societies to do the same at their respective levels.

That, clearly recognizing the health of individuals has many aspects other than medical care, such as education, housing, environmental control, transportation, civil rights, and the alleviation of poverty, the American Medical Association continue to show an active, innovative and constructive interest in these non-medical components of health services.

That the AMA and the constituent and component medical societies seek the active cooperation of all physicians, both as individuals and as members of medical staffs, in medical service projects for areas in need of medical services.

That the AMA, through its Council on Health Manpower, in conjunction with county and state medical societies and other professional, education, and lay associations, continue to explore and develop expedients to overcome health manpower shortages.

That the association, in its future declarations and activities directed toward the alleviation of shortages in health services and personnel, underscore the fact that these shortages are not due merely to an insufficient number of health professionals across the board, and emphasize that maldistribution of practitioners geographically, by profession, and by specialty is an equally important factor in depriving communities of an adequate supply and spectrum of health services.

That the association publicize the reasons for the maldistribution, as outlined in this section, and stress that the voluntary correction of these deficiencies requires public cooperation and community action in addition to the measures taken by the health professions.

That an appropriate committee of the AMA immediately begin to formulate a policy on physicians' assistants, particularly with regard to their responsibilities, limitations on their services, and supervision of their services by qualified physicians.

That the AMA reaffirm the principle that the basic responsibility for the medical care of patients lies with their physicians of record and that that responsibility cannot be legally or morally delegated.

That the AMA approve in principle certification of educational programs for physicians' assistants but oppose licensing of these individuals by any state agency.

That the association's Law Division upon request assist the state medical societies in identifying and avoiding any legal hazards that may accompany the employment of physicians' assistants.

In seeking as its goal the highest quality and availability of patient care, the American Medical Association advocates factual investigation and objective experimentation in new methods of delivery of health care, while still maintaining faith and trust in the private practice of medicine and pride in its accomplishments.

That the association, in appropriate public statements, emphasize the concept that differences in education, state laws, culture and income levels create problems that may necessitate different systems of delivering medical care for different population groups and different geographic areas.

Urge state medical associations to establish bureaus or departments of economic research, development and planning to study, develop and disseminate data concerning the economic aspects of medical practice.

Through the AMA's Departments of Survey Research and Economic Research, continue to assist state associations in collecting such data and to act as a clearinghouse for data so gathered.

Encourage state medical associations to designate representatives to deal energetically with third party agencies and programs, utilizing the concept of usual, customary or reasonable charges.

That the AMA reiterate its support of sound, existing mechanisms, such as public grievance and adjudication committees, and utilization and peer review committees, which state and county medical societies have found to be most appropriate and effective for the consideration of fees and the costs of medical and related care.

Endorse the principle of voluntary, lifelong postgraduate study for all physicians and continue and accelerate the development of programs and incentives for such study.

That the AMA encourage and assist all state medical associations to devise programs for voluntary post-graduate study designed to maintain medical education at the optimum level with the primary objective of assisting the physician in rendering professional services to his patients. These programs of postgraduate study should be mindful of the many demands on the time of the busy physician, and his responsibilities to his patients and his practice, and should be least disruptive to the provision of medical services.

That the association obtain information from each state medical society as to whether special requirements have been imposed on physicians who render services to patients under the provisions of tax-supported programs and obtain the specifics of what those requirements are.

That in those states where the health or welfare departments have imposed special requirements on physicians to participate in their programs, the medical society reject those requirements and that, if the need for such regulation can be demonstrated, the state medical society, education department, and health department cooperatively develop standards to be incorporated into the education law and enforced on all physicians of that state, thereby eliminating double standards for m dical practice and restoring the licensing authority to the proper agency.

The AMA, on the basis of the data received from the state medical societies, (1) continue to identify the services that comprise good medical care; (2) develop guidelines that state and county medical societies may use in evaluating needs and priorities of medical services in their respective areas, and (3) ensure that these data and guidelines are widely distributed and publicized.

That the present structure of the association be retained and that it be strengthened by improvements and modifications in its function.

That on implementation of the program for organization and reorganization, a planning council with appropriate subcommittees be formed for the purpose of processing data and formulating policy recommendations for the consideration of the Board of Trustees and the House of Delegates.

Education: In December, 1968, the House agreed that "an ultimate goal is unification of the internship and residency years into a coordinated whole." To move closer to that goal, in this meeting the House adopted the following statements:

"After July 1, 1971, a new internship program shall be approved only when the application contains convincing evidence that the internship and the related residency years will be organized and conducted as a unified and coordinated whole.

"After July 1, 1975, no internship program will be approved which is not integrated with residency training to form a unified program of graduate medical education."

The House also adopted or approved essentials of approved programs in continuing medical education; essentials of an accredited educational program for histologic technicians; revision of essentials of approved internships and residencies pertaining to part-time appointments; essentials for approval of examining boards in medical specialties; revision of essentials of approved residencies in child psychiatry; revision of essentials of approved internships and residencies to add statement on

employment relationship of house officers; revision of essentials of approved residencies in neurological surgery; revision of essentials of approved residencies in pathology; and revision of essentials of approved residencies in internal medicine.

A permanent Section on Neurological Surgery was created in the Scientific Assembly of the AMA.

Professional Liability: The House approved a Board report stating that liability insurance protection is essential so that physicians may continue to provide needed medical care to the public. "It has been concluded," the report said, "that the best way to provide such assurance is on a collective, rather than an individual basis, under programs jointly sponsored by the American Medical Association and the respective state medical association. . . . Minimum standards for an effective sponsored insurance program are being developed" and the Professional Liability Committee of the Board "is seeking with the insurance industry a means for instituting qualified insurance programs under such joint sponsorship with state associations which elect to participate."

Nurses and Other Allies: The following AMA position statement on nursing was adopted:

"The American Medical Association recognizes the need for, and will support efforts to increase, the number of nurses; recognizes the need for, and will facilitate the expansion of, the role of the nurse in providing patient care; encourages and supports all levels of nurse education; will promote and influence the development of a hospital nursing service, similar to a medical care service, under the leadership of a chief of professional service, aimed at increased involvement in direct medical care of the patient; supports the concept of the physician-led health team; and will seek constructive collaboration with the total nursing community."

The House also resolved that "the American Medical Association undertake a thorough investigation of a method to bring allied professions into a collaborative relationship with the AMA such as the establishment of a new class of membership;" and "that consideration be given to preparing 'essentials' for those categories of the allied health personnel groups which do not have them, and that the opportunity for vertical and horizontal mobility be considered in determining these 'essentials.'"

Convention Sites and Dates: The 122nd Annual Convention of the AMA, originally scheduled for July, 1973 in New York, has been changed to June 24-28. It will be in New York.

The Clinical Convention of 1972, originally planned for Atlanta, will be held in Cincinnati, Ohio. The 1976 Clinical will meet in Philadelphia.

This is the line-up now:

	Annual	*Clinical*
1970	Chicago	Boston
1971	Atlantic City	New Orleans
1972	San Francisco	Cincinnati
1973	New York	Anaheim
1974	Chicago	Portland, Ore.
1976		Philadelphia

Drugs: The House took a number of important actions in connection with drugs. Among them:

That the AMA "encourage Committtees on Pharmacies and Therapeutics in each hospital to review drug reactions and related problems and to take appropriate control measures and to initiate informational programs."

That the AMA "seek passage of legislation for control of the manufacture and distribution of barbiturates and amphetamines."

That the AMA "expresses the concern of the medical profession that consumer protection be assured through more adequate surveillance of proprietary drug advertisements by private organizations and more effective cooperation in enforcement of applicable regulations by responsible governmental agencies."

That the AMA "supports dispensing by pharmacists of all medications in child-protective containers, and encourages acceptance of the containers by parents."

And that it is contrary to the public interest to repeal or modify "anti substitution laws and regulations in order to permit the filling of prescriptions with therapeutic agents not intended by the prescribing physician." The House declared its intention "vigorously to support the maintenance and enforcement of antisubstitution laws and regulations."

Hospitals: The House resolved that "the terms 'negative,' 'within normal limits,' and 'normal' be approved by the JCAH as acceptable designations for use in hospital charts."

It also resolved:

That the AMA request the JCAH to specify that a Joint Conference Committee "include, where feasible, adequate representation from community-based physicians elected by the medical staff."

That the AMA reaffirm its position that "general practitioners should have the opportunity to practice medicine as active staff members in hospitals and should be granted privileges commensurate with their training and demonstrated abilities."

And that the AMA suggest that "medical staffs consider revising their respective hospital medical constitutions and bylaws to differentiate clearly between medical and administrative duties."

Miscellaneous: The House supported the Board's plan to establish a wholly owned, separate subsidiary corporation to engage in publication and possibly other related activities now carried on by the AMA in order to gain various economies, lower costs and better administrative and accounting procedures.

Delegates adopted a Board proposal to undertake a "Communications Program for the 1970's," consisting of television documentaries, educational advertising, media relations and other related activities "to improve public understanding and opinion of the profession."

Approval was given to Report A of the Judicial Council, which said, among other things, that "It is not in itself unethical for a physician to own a for-profit hospital or interest therein. The use the physician makes of this ownership or interest may, however, be definitely unethical. For example, for a physician to send a patient to such a hospital or to prolong a patient's stay in the hospital for his financial benefit would be unethical."

The bylaws were amended to permit osteopaths in military service to become service members of the AMA.

The House resolved to "support continuing efforts by the American Medical Association to inform the medical profession of the value and benefit to be realized from the implementation of adequate peer review programs" and directed the Board, the Council on Medical Service and "other appropriate sections of the AMA" to give this project "the highest priority and emphasize its urgency to all state and component medical societies."

Mindful of its obligation to protect public health, the House called on each state society "to take whatever steps are necessary to inform state legislators about the health hazards posed by the cult of chiropractic." It also encouraged medical schools "to include specific information in their curricula regarding the nature of the health hazard to individuals . . . posed by quackery in general and the unscientific cult of chiropractic in particular."

The House directed the AMA to make a detailed and comprehensive study and analysis of the methods and requirements for reporting infant mortality statistics "by those nations that are alleged to have a lower rate of infant mortality than that of the United States."

Delegates resolved that the AMA continue its efforts "to alert the American people. . . to the ever increasing health hazards of environmental pollution and to the urgent need for expanded research and effective control measures;" and that the AMA "further extend and intensify its present activities in pollution control and

improvement of environmental health."

Considering the plight of prisoners of war in North Vietnam, the House recommended that, "in the best medical interests of both servicemen and their families, the World Medical Association and/or other appropriate international organizations be requested to use their influence with those countries which do not subscribe to the Geneva Convention to the effect that (a) a list of prisoners' names be furnished, (b) inspection of prisoner compounds by neutrals be carried out, and (c) medical supplies and food parcels, as well as mail, be distributed to prisoners."

Awards: Charles B. Huggins, M.D., of the Pritzker School of Medicine, Chicago, was presented the Dr. Rodman E. and Thomas G. Sheen Award at the opening session of the House, along with the check for $10,000 which accompanies the award.

Special awards were presented to the stars, creator and producer of the ABC-TV program, "Marcus Welby, M.D." Robert Young (who portrays Dr. Welby); James Brolin (who plays the assistant, Dr. Kiley); David Victor, creator and executive producer; and David O'Connell, producer, all received plaques in front of the House. The program and the people responsible for it were cited for portraying "the human understanding and uncompromising care which physicians give to their patients."

Also honored at the opening session of the House were the AMA winners in the 21st International Science Fair, whose exhibits were on display throughout the Scientific Assembly.

The winners were Beverly Fordham, a junior at Bryan Adams High school in Dallas: "Determination of Alpha Vigilance via Electroencephalography;" and Kevin Boran, senior at Lawton's Hill school in Pottsville, Pennsylvania: "Effects of Antidiuretic Hormone on Sweating Activity and Sweat Composition."

DON E. WOOD, M.D.
EUGENE F. SENSENY, M.D.
FRANK H. GREEN, M.D.
JACK E. SHIELDS, M.D.
JOHN FARQUHAR, M.D.

Reports of Committees

Executive Committee

The Executive Committee has met regularly throughout the year, usually with a full attendance of all members. In this report I will not attempt to go into great detail as to the activities of the committee inasmuch as the minutes have been published regularly in *The Journal* and widely distributed. Also copies of all minutes are in the hands of the Reference Committee for their review.

However, in addition to the usual housekeeping responsibilities of the committee, I would like to call attention to just a few of the transactions handled by your Executive Committee during the past year.

A letter from the State Department of Public Welfare concerning implementation of Title XIX was referred to the Board of Trustees.

Approved a joint meeting of the executive committees of ISMA and the Indiana Hospital Association.

Discussed the plans for the "Teen Health Week" program and this was referred to the Board of Trustees for their consideration.

At the request of the Governor, made suggestions for appointments to the Day Care Committee; the Civil Defense Committee and the Board of Medical Registration and Examination.

Approved the recommendation of the Commission on Medical Education and Licensure that service certificates be prepared for participants in the Preceptor Program.

Met with the president of the Woman's Auxiliary of ISMA to discuss program and planning for the coming year.

Approved the budget for the 1970 fiscal year and referred same to the Board of Trustees for their approval.

Recommended certain changes in the budgeting as recommended by the George S. Olive Company, auditors.

Referred to the Board of Trustees a request from the county societies that Blue Shield prepare reports on a county basis of the usual and customary charges.

Referred to the AMA Legal Department many questions concerning the legality of certain provisions in the Medicaid program.

Reviewed the mandatory orientation program.

Agreed to present the name of Dr. James O. Ritchey for the Sheen Award.

Referred to the Board of Trustees a request from Blue Cross-Blue Shield for an increase in rates for the physicians' group.

Received a report from the executive secretary that the CHAMPUS program was now exceeding a million dollars per year.

Referred to the Board of Trustees a suggestion that the ISMA extend an official invitation to the AMA to hold its 1975 Clinical Session in Indianapolis.

Approved the request of the Indiana Chapter of SAMA to hold meetings in the headquarters building.

Reviewed the actions of the National Association of Blue Shield Plans.

Made recommendations for appointment of members to the Indiana Advisory Hospital and Health Facility Planning Council.

Approved a program of the Cerebral Palsy of Indiana to conduct an additional program on Rubella vaccine.

Referred to the Commission on Medical Economics and Insurance the suggestion of J. Russell Townsend that the income limits of the ISMA Disability program be increased to $1,000.

Report from G. O. Larson, M.D., president of the Indiana State Advisory Comprehensive Health Planning Council, was given.

Approved the submission of a resolution from Dr. Jack Hickman for possible presentation to the AMA requesting a decrease in the number of approved residencies.

Authorized the president to sign a new contract between ISMA and the OCHAMPUS program.

Referred to the Board Committee on Fiscal Matters the requirement of the Federal government that the employees' retirement plan of the association be changed by January 1, 1971.

Authorized the appointment of a special committee to discuss naming some of the rooms in the headquarters building as memorials to individuals.

Received a report that a Section on College Medicine had been formed.

Received several reports from individuals and county societies expressing their opinion on the Himler Report.

Received letters from several Indiana congressmen concerning the association's letter voicing objection to the Senate Finance Committee report inferring that five physicians from Indiana were guilty of receiving more than $25,000 under the Title XIX program.

Reviewed proposed advertising by the National Blue Shield Plan and voiced objection to the copy content.

Received opinions from legal counsel on several matters.

Received a report that the anesthesiologists of Indiana were using the American Society of Anesthesiologists Relative Value Guide.

Reviewed the MECO project and information from the Illinois State Medical Society regarding this program and referred the information to the Commission on Medical Education and Licensure.

Ordered the distribution of comments on the Himler Report made by an English physician currently in practice in Indiana.

Heard a report from the president concerning conferences he and the executive secretary had had with the oficials in the Department of HEW concerning the Senate Finance Committee report.

Approved a suggestion of the executive secretary that the State Department of Welfare be informed that there was no reason for doctors to be required to sign a Civil Rights and Fraud Statement on claims under Title XVIII and Title XIX inasmuch as members of the association subscribe to the Principles of Medical Ethics which provided this protection.

Formulated a proposal to RMP for expansion of joint field service under ISMA direction for Indiana State Medical Association and RMP.

Reviewed an exchange of correspondence between the headquarters office and the Secretary of Defense concerning release of information on physicians and medical corpsmen who are being discharged from the military service.

Received reports from representatives to the National Conference on Voluntary Health Agencies and the Regional Meeting on Medicine and Religion.

Reviewed copies of letters concerning Procter and Gamble sponsorship of CBS programs on health.

Received a proposed bill concerning letting down the bars for licensing of foreign physicians. This was referred to the Board of Trustees.

Recommended to the Board of Trustees that the association oppose a proposed bill on the Workman's Compensation.

Reviewed plans for the facilities of the 1970 annual meeting in South Bend.

Approved the Indiana Chapter of Society of Internal Medicine moving their office into the headquarters office of the association.

Referred to the Board of Trustees a proposal for membership in the Indiana Traffic Safety Council.

Heartily recommended the efforts of

Dr. Charles A. Bonsett on the formation of the Indiana Medical History Foundation to turn the old Pathology building located at Central State Hospital into a medical museum.

Referred to the Board of Trustees a recommendation for legislation made by the Commission on Public Health.

Referred to the Board of Trustees a letter from the Woman's Auxiliary concerning the ISMA collecting dues for the state auxiliary.

Received a report from Judge Hamill concerning the settlement of the suit between the Indiana State Medical Association and Blue Cross which will prohibit Blue Cross from furnishing professional services.

In addition, at each meeting, the Executive Committee reviewed the financial status of the association, as reported by the treasurer, as well as the membership report and suits filed against physicians for malpractice.

Your Executive Committee has had a busy year with meetings consuming from six to eight hours of time.

Medical Defense Activities

1. *Malpractice Cases.* A year ago, at the time of this report, August 1, 1969, the following four cases were pending before the committee:

Case 307—Suit filed March 22, 1962. Pending. (Expense to date, $1,042.73.)

Case 309—Suit filed December 10, 1964. Pending.

Case 312—Suit filed December 7, 1965. (Case closed April 1, 1970. Expense for attorney's fee $4,314.12.)

Case 313—Suit filed September 5, 1967. Pending.

Since August 1, 1969, and up to August 1, 1970, one new case has been filed.

2. *Medical Defense Fund Statement from August 1, 1969 to August 1, 1970:*

Bank Balance, August 1, 1969	$ 5,264.46
Receipts	9,968.61
Total Cash and Receipts August 1, 1970	$15,233.07
Disbursements:	9,592.65
Balance on hand August 1, 1970	$ 5,640.42

The Journal

The financing problems of *The Journal* remain one of our biggest headaches. What we have gained in reduction of production costs has been offset in the drop in revenue from advertising. The advertising continues to fluctuate and at the rate we are going for 1970, the income from advertising may be one of the lowest in years. Despite the financial situation, it does not seem prudent to lower the standards of *The Journal*, which is recognized as one of the best state journals published.

Listed below is a comparative report of *The Journal* operations over the past several years and the first six months of 1970.

The following table shows the number of journal pages for the past six years (includes inserts).

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. Pages per Issue
1964	1051	71	423	29	1474	123
1965	998	68	464	32	1462	122
1966	789	50	781	50	1570	131
1967	1041	58	751	42	1792	149
1968	1068	61	696	39	1764	147
1969	1041	67	509	33	1550	129

The table below shows the total printing costs of *The Journal:*

Year	Total Printing Cost	No. of Pages (Inserts excluded)
1965	$35,957.50	1416
1966	$41,795.32	1410
1967	$49,958.15	1450
1968	$50,709.62	1463
1969	$42,916.62	1312
(6 months)	$21,751.16	648

A comparison of advertising revenues for the first six months of the last four years, with a like figure for 1970 is as follows:

State Medical Journal Adv. Bureau	1966	1967	
	$18,069.54	23,468.96	
	1968	1969	1970
	24,153.24	17,086.59	15,791.12
	1966	1967	
Sold Direct by Journal	2,687.76	3,056.68	
	1968	1969	1970
	7,200.10	2,557.80	2,268.80
	1966	1967	
Total	$20,757.30	$26,525.64	
	1968	1969	1970
	$31,353.34	$19,644.39	$18,059.92

MEMBERSHIP REPORT

	December 31, 1969	July 31, 1969	July 31, 1970	AMA, July 31, 1970
1st District				
Gibson	13	13	12	12
Perry	7	7	8	8
Pike	3	3	3	3
Posey	7	7	7	7
Spencer	4	4	3	3
Vanderburgh	235	233	239	237
Warrick	6	6	7	7
TOTAL	275	273	279	277
2nd District				
Daviess-Martin	20	20	19	16
Greene	14	14	14	10
Knox	38	38	37	36
Owen-Monroe	84	84	83	78
Sullivan	13	13	13	12
TOTAL	169	169	166	152
3rd District				
Clark	47	47	47	46
Dubois	24	24	25	23
Floyd	41	41	44	41
Harrison-Crawford	10	10	9	9
Lawrence	25	25	27	24
Orange	9	9	8	8
Scott	5	5	6	6
Washington	10	10	7	7
TOTAL	171	171	173	164
4th District				
Bartholomew-Brown	50	50	55	51
Dearborn-Ohio	17	16	15	15
Decatur	11	11	11	10
Jackson-Jennings	23	23	23	23
Jefferson-Switzerland	31	31	28	27
Ripley	10	10	8	7
TOTAL	142	141	140	133
5th District				
Clay	15	15	13	13
Parke-Vermillion	16	16	17	17
Putnam	18	18	19	19
Vigo	116	115	119	118
TOTAL	165	164	168	167
6th District				
Fayette-Franklin	14	14	16	16
Hancock	23	23	26	26
Henry	35	35	39	37
Rush	12	12	12	12
Shelby	19	19	20	18
Wayne-Union	74	74	74	72
TOTAL	177	177	187	181
7th District				
Hendricks	20	20	20	20
Johnson	34	34	33	31
Marion	1072	1062	1056	1054
Morgan	18	18	19	18
TOTAL	1144	1134	1128	1123
8th District				
Delaware-Blackford	120	116	121	118
Jay	16	16	16	11
Madison	109	107	106	76
Randolph	18	18	17	13
TOTAL	263	257	260	218
9th District				
Benton	9	9	9	9
Boone	21	20	19	17
Clinton	15	15	14	14
Fountain-Warren	11	11	11	11
Hamilton	18	18	16	15
Montgomery	24	24	22	22
Newton	5	5	5	5
Tippecanoe	140	140	141	134
Tipton	11	11	11	11
White	8	8	7	7
TOTAL	262	261	255	245
10th District				
Jasper-Newton	7	7	7	7
Lake	454	452	453	423
Porter	52	52	51	50
TOTAL	513	511	511	480
11th District				
Carroll	9	9	7	7
Cass	33	33	36	33
Grant	71	71	71	71
Howard	68	68	65	65
Huntington	19	19	19	19
Miami	14	14	15	14
Wabash	29	29	33	30
TOTAL	243	243	246	239

12th District				
Adams	14	14	13	13
Allen	310	307	314	301
De Kalb	23	23	23	23
LaGrange	8	8	10	9
Noble	14	14	12	12
Steuben	12	12	11	11
Wells	47	47	46	46
Whitley	17	17	16	15
TOTAL	445	442	445	430
13th District				
Elkhart	114	114	114	110
Fulton	9	9	9	9
Kosciusko	17	16	13	13
La Porte	96	96	94	86
Marshall	26	26	25	25
Pulaski	5	5	5	2
St. Joseph	240	235	232	231
Starke	6	6	7	7
TOTAL	513	507	499	482
SUMMARY				
1st District	275	273	279	277
2nd District	169	169	166	152
3rd District	171	171	173	164
4th District	142	141	140	133
5th District	165	164	168	167
6th District	177	177	187	181
7th District	1144	1134	1128	1123
8th District	263	257	260	218
9th District	262	261	255	245
10th District	513	511	511	480
11th District	243	243	246	239
12th District	445	442	445	430
13th District	513	507	499	482
TOTAL	4482	4450	4457	4291

DONALD M. KERR, M.D.,
Chairman
BURTON E. KINTNER, M.D.
LOWELL H. STEEN, M.D.
MALCOLM O. SCAMAHORN, M.D.
PETER R. PETRICH, M.D.
LESTER H. HOYT, M.D.
HUGH K. THATCHER, M.D.

Grievance Committee

The Grievance Committee held meetings on April 19 and July 12, 1970.

As of August 1, 1970, 16 cases were considered during the year. Eight new cases were filed during the year. All cases except four have been closed.

The ISMA Grievance Committee continued to follow the procedure of recent years. (1) Receipt of complaint is acknowledged by a letter which states that action can proceed only after receiving the complainant's permission to forward a full copy of the complaint to the physician or physicians named therein, along with identification of those filing the complaint; (2) Should the requested permission be received, the physician named is asked to attempt a personal settlement of the complaint; (3) Should the physician be unsuccessful or should he request that his county medical society attempt settlement, the matter is so referred with the ISMA Grievance Committee retaining responsibility as the rules governing it require. It is the recommendation of the ISMA Grievance Committee that a greater attempt be made at the local level to settle differences before the state committee is involved.

It is important in maintaining effective function of the ISMA Grievance Committee that all county society grievance committees and county society secretaries abide by the 1962 House of Delegates directive in reporting disciplinary action taken at the local level.

The 1967 House of Delegates directed that the publication *Purposes, Rules and Procedure of the Board of Appeals on Patient-Physician Relations* (The Grievance Committee) approved by the Council on April 26, 1952, be brought up to date. This matter has not been completed and it is the recommendation of the ISMA Grievance Committee that the publication be brought up to date.

The Grievance Committee wishes to thank the members of ISMA who have been called upon to assist in discharging its responsibility. We have received excellent help.

WALLACE R. VANDENBOSCH, M.D.,
Chairman
RICHARD S. BLOOMER, M.D.,
Vice-Chairman
ROBERT G. YOUNG, M.D.,
Secretary
KENNETH L. OLSON, M.D.
EARL W. MERICLE, M.D.
EUGENE S. RIFNER, M.D.
JOHN M. PARIS, M.D.
WILSON L. DALTON, M.D.
WILLIAM R. NOE, M.D.
HUGH K. THATCHER, JR., M.D.

Student Loan Committee

The Student Loan Committee held four meetings during the past year. The committee interviewed 10 students and loans were granted to nine applicants for a total of $8,700.00; one applicant received a loan from another source.

Under the Guaranteed Loan Plan with the Indiana National Bank, which was instituted December 1, 1963, the association has on deposit with the bank $20,810.00 to guarantee loans totaling $260,000.00. As of July 31, 1970, 105 loans, totaling $92,500.00, have been granted under this plan. Forty-one loans have been converted to installment loans in the amount of $37,960.10. To date there have been two defaults—one in the amount of $606.54 and the other in the amount of $1,913.00. The Indiana National Bank has been reimbursed for these two loans from the Student Loan Fund. On July 10, 1970 a suit was filed in Municipal Court of Marion County against the physician who owes the association $606.54 plus interest.

A report on the Loan Fund which was under the association management from October, 1955, to December 31, 1963, follows:

Total loaned to 117 students	$58,458.36
Total repaid by loanees as of July 31, 1970	$57,646.32
Total amount outstanding, July 31, 1970	$ 812.04

Of the 117 who received loans,
113 have repaid in full
*4 are making payments

*Total due on above 4 loans still outstanding	$ 812.04

All delinquent accounts have been collected.

The Student Loan Fund does provide an essential service to students in need of financial help and it is the recommendation of the Student Loan Committee that this type of loan procedure should be continued.

LESTER D. BIBLER, M.D.,
Chairman
JAMES O. RITCHEY, M.D.,
Vice-Chairman
JOE DUKES, M.D.,
Secretary
LOWELL H. STEEN, M.D.
LESTER H. HOYT, M.D.
GLENN W. IRWIN, M.D.

Future Planning Committee

Doctor Rifner brought us up-to-date regarding AMA's attitude and plans on the "Himler Report." He reported a new, permanent Future Planning Committee of AMA has been organized. Its membership is staggered and rotating. Of the nine members, four are appointed by the speaker of the house of delegates (two being delegates and two at large); four are appointed by the board of trustees (two being trustees and two at large), and one is appointed by SAMA.

The ISMA Future Planning Committee recommends that it be dissolved at the end of this work year (October 1970) and be replaced by a committee like the AMA's committee. This is to make the committee responsible to the power and influence structure of ISMA. We recommend that this committee send brief progress reports to the delegates and trustees at least every three months. It seems important to keep these bodies informed and considering the merits of any resolutions this committee may be working toward offering at the annual meeting.

This Future Planning Committee should have a "blue sky" function, particularly in the areas of (1) the effective restructuring and functioning of ISMA, (2) the delivery of health care systems, and (3)

educational programs needed to produce the health care planned in No. 2.

Minutes of meetings of all other committees should be distributed to the chairman of the Future Planning Committee so that this committee doesn't spend time "blue skying" something that is already being planned or implemented by another committee.

The Future Planning Committee should be anticipating the future—not waiting for crises. They should talk with organizations and individuals interested and involved in health care delivery such as labor unions, insurance companies, and the ISMA executive secretary for knowledge of their needs, plans and expectations.

We should resubmit some of our 1969 resolutions. We should include those dealing with mail ballot voting for ISMA officials and the 30% yes vote of membership represented to make an election valid. We should exclude those that deal with length of term of office.

We wish to propose a resolution affecting the annual conventions starting in 1971. We propose that ISMA sponsor no scientific programs. All programs will be dealing with business, economics, public relations, politics or social events. We should invite the state specialty organizations (including the Academy of General Practice) to offer any scientific programs they wish in conjunction with the annual meeting of ISMA. When any specialty organization wishes to affiliate with ISMA, its officers should replace ISMA specialty section officers and the specialty section as such be phased out.

We would again encourage ISMA to invite specialty organizations to affiliate with ISMA using ISMA's administration facilities and personnel.

ISMA must be a consensus—not a majority rule organization. Organized medicine needs to find points in common. We must represent most, if not all, physicians or lose our strength. Policies which are divisive and cannot accommodate a variety of opinions weaken any influence we can exert on the future of health care delivery.

G. O. LARSON, M.D., *Chairman*
ED TYLER, M.D., *Vice-Chairman*
MAURICE E. GLOCK, M.D.
JAMES FITZPATRICK, M.D.
A. W. RATCLIFFE, M.D.
PAUL A. F. WALTER, III, M.D.
GEORGE M. HALEY, M.D.
CHARLES F. GILLESPIE, M.D.
LESLIE BAKER, M.D.
RALPH V. EVERLY, M.D.
LOWELL H. STEEN, M.D. (*ex-officio*)
MALCOLM O. SCAMAHORN, M.D. (*ex-officio*)
PETER R. PETRICH, M.D. (*ex-officio*)
DONALD M. KERR, M.D. (*ex-officio*)
FRANK B. RAMSEY, M.D. (*ex-officio*)

Committee on Medicine and Religion

Why is the Committee on Medicine and Religion trying to urge doctors and clergy to get together? Why not a committee of doctors and dentists, or lawyers? After all, our patients have problems in those fields, as well as religion. Why should a doctor send a patient to a minister? For the same reason a minister sends his parishioner to a doctor when the parishioner gets sick with a physical illness.

When our patients "come apart" at the threat of death or need a stabilizing friend, they could use a minister's help. Do you have a patient who is too sensitive about guilt? How about sending him to a specialist on guilt—a minister, a rabbi, or a priest?

"But I know a minister who is a poor one to be seeing my patients if they are guilty. This fellow would make anyone feel like he's doomed for hell." O.K., so some ministers don't handle guilt very well with parishioners; how about sending the patient to another minister who does know how to advise on guilt without causing problems? Where would one find such a clergyman?

The Committee on Medicine and Religion is trying to promote getting together doctors and ministers just to see what mutual problems can be worked out. Why not try making a simple conversation with a minister over a cup of coffee or over the telephone? There are many ministers in your area who could help your patients. Make it easy on yourself; know the ministers in your town. Perhaps one of them can ease your patient's problem of finding himself sometime.

B. E. KINTNER, M.D., *Chairman*
JOHN C. SLAUGHTER, JR., M.D.
DONALD E. WOOD, M.D.
JOHN E. READ, M.D.
EDWIN B. BAILEY, M.D.
HUNTER SOPER, M.D.

Reports of Commissions

Constitution and Bylaws

The Commission on Constitution and Bylaws has met to consider several matters which have been referred to them and makes the following recommendations for changes in the Constitution and Bylaws.

Constitutional Changes

The following changes in the Constitution are presented at this time but final action cannot be taken until the 1971 meeting under provisions for amending the Constitution contained in Article XIV of the Constitution.

Be It Resolved that Article VI of the Constitution be amended by deleting the last sentence of the Article which reads "seven Trustees shall constitute a quorum" and insert in lieu thereof "A majority of elected Trustees shall constitute a quorum."

Be It Resolved that the present Section 3 of Article VIII be deleted and the following be inserted in lieu thereof: "Section 3.—Special meetings of either the Association or the House of Delegates shall be called by the President upon receipt of a petition signed by 30 delegates or 100 members. The signed petition shall contain the names of at least ten delegates or 34 members from each of at least three Board districts. Upon receipt by the President of such a petition, the President shall within 30 days thereafter issue a call for such special meeting at a time and place to be fixed by the President. The President, in specifying the time of such special meeting, shall fix the same as soon thereafter as reasonable and suitable arrangements can be made."

Be It Resolved that Article IX, Section 1 be amended by striking the word "thirteen" and inserting in lieu thereof the word "the" which will then make Section 1 read as follows: "Section 1.—The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, an Assistant Treasurer and the Trustees, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member."

Be It Resolved that Article IX, Section 4 be anmended by striking the word "Trustee" in the first sentence and inserting in lieu thereof the following: "Trustee (s)" or "alternate Trustee(s)" which will make Section 4 then read as follows: "Section 4—The Trustees shall be elected by the respective district societies. If any district fails to meet and elect its Trustee (s) or alternate Trustee(s) by the time of the expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election."

Be It Resolved that Article IX, Section 5 be amended by striking the word "an" in the first sentence and adding after the word Trustee "(s)" which will make Section 5 then read as follows: "Section 5. Each Trustee district shall elect alternate Trustee(s) whose term of office shall be the same as the Trustee, namely three years. The alternate Trustee shall be elected in a year during which there is no Trustee elected.

"The duties of the alternate Trustee shall be:

"1. To represent the Trustee district in the absence of the regularly elected Trustee.

"2. To vote only in the absence of the regularly elected Trustee either in the House of Delegates or in Board meetings where he represents the regularly elected Trustee."

The committee recommends the following amendments to the Bylaws which may be adopted and become effective at this meeting.

Be It Resolved that Chapter I, Section 1 be deleted in its entirety and present Section 2 be renumbered Section 1; present Section 3 be renumbered Section 2; present Section 4 be renumbered Section 3; and present Section 5 be renumbered Section 4.

Be It Resolved that Chapter II be amended by adding a new section as follows: "Section 5—Any of the component member county societies wishing to invite the Indiana State Medical Association to hold its annual meeting in its locality shall submit an invitation in writing at least five years in advance to the Board of Trustees. The Board of Trustees shall make an investigation of the facilities and in turn recommend the location of the annual meetings for concurrence by the House."

Be It Resolved that Chapter IV, Section 2 be amended by adding the following sentence at the end of the first paragraph "Two delegates are to be selected by the Indiana Chapter Student American Medical Association who shall be seated though without power of vote."

Be It Resolved that Chapter XXIX, Section 2 be amended as follows: By adding a new sentence, at the end of the first paragraph, which reads as follows: "At least one of which shall be organized for the sole purpose of studying the addresses of the President; President-elect; report of the Executive Secretary; and chairman of the Board of Trustees. This committee shall be mandated to translate recommendations made by these officers through resolutions for presentation to the House. . .", the balance of the section to remain the same.

Be It Resolved that Chapter XXXI, Section 4 be amended as follows: "Wherever the word trustee appears there shall be added an "(s)" and the word "a" preceding the first Trustee shall be deleted which will then make the Section read as follows: "Section 4—Each district society shall organize by electing a president, a secretary, and a treasurer and Trustee (s) and alternate Trustee(s) as the current Trustee(s) term and alternate Trustee(s) term for the district expires, and such others as may be provided for in its Constitution and Bylaws. The office of secretary and treasurer may be held by the same physician. The Trustee(s) shall continue to have the same duties and terms as are set forth in the Constitution and Bylaws of this Association."

Be It Resolved that Chapter XXXI be amended by adding a new section to read as follows: "Section 5.—Each district society shall have one Trustee and one alternate Trustee for each 600 active members or major fraction thereof but in any event each district shall have one Trustee and one alternate Trustee. The term of each trusteeship newly created by the numerical growth of a district shall begin at the organization meeting of the Board immediately following the adjournment of the second meeting of the House of Delegates at the next annual meeting, in accordance with Chapter VII, Section 1."

Be It Resolved that Chapter XXXI, present Section 5 be renumbered Section 6; the present Section 6 be renumbered Section 7; the present Section 7 be renumbered Section 8; the present Section 8 be renumbered Section 9; and the present Section 9 be renumbered Section 10.

GORDON S. FESSLER, M.D.,
Chairman
ELI GOODMAN, M.D.
DONALD B. GARVIN, M.D.
WALLACE A. SCEA, M.D.
EVERETT SMITH, M.D.
WILLIAM M. SHOLTY, M.D.
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JOSEPH F. FERRARA, M.D.
GEORGE YOUNG, M.D.
CHARLES PLANK, M.D.

Legislation

The Commission on Legislation met several times throughout the year on this off-year for our State Legislature.

We discussed current national congressional legislation. In addtiion, we basically followed the philosophy of the AMA and their suggestions based on their Washington office's assay of various bills.

The major prediction is, of course, a national compulsory health insurance program for coverage of all the people in the United States; the inside political analysts tell us this bill is not five or ten years away but only two or three years. Organized medicine—both local, state and national—will have to take a stand on this issue.

As concerns our biennium which meets in January of 1971, we will have great concern with bills to be introduced that affect the public health and welfare as well as physicians collectively and individually.

To enumerate a few:

1. A change in the law concerning foreign medical graduates and their ability to obtain a license in Indiana.
2. Reporting by laboratories of findings concerning VD to the Indiana State Board of Health.
3. Authority for local boards of health to obtain legal counsel above and beyond that now provided to help implement new ordinances and develop new ones.
4. Possible changes in Medicaid or Title 19.
5. An act concerning provision and regulation of emergency medical services, describing the powers and duties of the State Board of Health related thereto and making an appropriation therefor.

These are but a few of the items that we must be concerned with.

As chairman during this off-year and because my tenure has expired on the commission, I want to personally thank all the members of this commission for their loyalty and dedication to duty.

The ISMA can be proud of the record of this most important commission down through the years.

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DON E. WOOD, M.D.

Governmental Medical Services

The commission has had many meetings this past year and many matters have been discussed. We have reviewed many of the unusual and outstanding CHAMPUS claims (former serviceman's dependents Medicare). Seven or eight members of the commission have reviewed these claims either in conference or on telephone conferences. Throughout the year we have had about five telephone conferences from the state headquarters to review the outstanding CHAMPUS claims. We had an organizational meeting on November 15, 1969; other meetings were on January 25, April 22, June 10 and July 8, 1970.

Some of the plans for the commission for the year included the following:

1. To find an alternate plan for Medicaid.
2. A utilization review of the CHAMPUS program.
3. A program to have a continuing updating of the Blue Shield and California Relative Value Scale Schedule.
4. Recommend to the anesthesiology section of the Indiana State Medical Association that re-negotiation for a new contract for anesthesia with the government in the CHAMPUS program be made.

In April, 1970, the commission met with Blue Shield representatives, Mr. Kilborn and Mr. VanDyke. We were unable to find a way to answer the problem of upgrading Blue Shield indemnities schedules. Actually we learned that all new plans (Blue Shield) were sold on a usual and customary fee basis. It remains a mystery as to what is a "usual and customary fee basis."

The commission heard complaints from the Indiana Association of Anesthesiologists and authorized the obtaining of a new contract for the group. In addition, the commission decided that the Indiana State Medical Association discuss and ask for increases in fees under the CHAMPUS program. An increase of two and one-half units was approved and agreed upon.

After many heated sessions and words, it was the desire of the commission that our Indiana State Medical Association must find a place of trust and loyalty within all those groups with which we deal. This should include the welfare department, Medicare and Medicaid and also Blue Shield.

As the year progressed, it was apparent that the fiscal agent for the government was falling back in its efforts to keep up with this fiscal portion. Many problems of tardy, unpaid, slow, underpaid claims became larger. Errors have been compounded and refractured as new problems of personnel and machines became apparent. We have been able to "bird dog" these problems with the able assistance of Blue Shield's Mr. Kilborn and Mr. VanDyke. Eye-to-eye and face-to-face conversation with representatives of Blue insurance and welfare have improved all our relations. We have attempted to greatly reduce the number of rejected claims in the Medicaid group of claims.

The Commission on Governmental Medical Services is very outspoken in its desire *not* to be a claims-investigating committee, but they were very willing to promulgate and adjudicate outstanding claims. Many errors in Medicare and Medicaid during the past 12 months were not the fault of physicians. It is our hope that this will become public information. The two-fold patient-physician relationship of the past has suddenly become three, four or even ten-fold, with Medicare and Medicaid programs, and the result has been of the same magnitude.

Physicians' complaints concerning claims have been reviewed and researched and we have tried to please all within the limits of the law.

The Indiana State Medical Association received and filed over 15,000 claims in the CHAMPUS program for a twelve-month period. Almost 15,000 claims were paid in the same period of time. The commission reviewed and approved an average of 15 claims per month.

As new members join our association we shall try to keep them informed as to the best way to process the paper work on CHAMPUS, Medicare and Medicaid. The financial outlays for these programs in Indiana are most staggering to a stable person and the most unbelievable task that a national health insurance could produce makes us realize that we have but put "three coins in a fountain." It was in the middle of this past summer that we heard from the Health, Education, and Welfare secretary that a price tag has been put upon one of the national health insurance plans. The price mentioned was close to forty billion dollars for one year.

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Public Health

The Commission on Public Health conducted a lengthy discussion on the air pollution problem. Present as a resource person at two of the meetings was Mr. Perry E. Miller, Director of the Engineering Bureau, Indiana State Board of Health. The commission was advised that in comparison to programs and activities in other states in the Midwest, Indiana falls considerably short. It was further advised that if an increased effective program is to be achieved in Indiana, the State Legislature must grant additional funds to accomplish this. Mr. Miller submitted a budget outlining specific needs to upgrade air pollution control programs.

The commission asked the Board of Trustees of the Indiana State Medical Association to give consideration and to undertake an in-depth study of the problem of air pollution. We further asked the Board of Trustees to formulate a resolution on air pollution from automobile exhaust and direct this toward the automobile manufacturers and that representatives of the Commission on Legislation be directed by the Board of Trustees to appear in person in support of the Indiana State Board of Health environmental control budget before the next convening of the Indiana General Assembly. These matters were discussed by the Board of Trustees and referred back to the commission for implementation. In carrying out this directive from the Board of Trustees, letters were sent to two members of the Pollution Subcommittee of the Health and Welfare Study Committee on Legislation informing these legislators of our organizational and commission's interest in the problem of air pollution and volunteering to make our group available to the study group for consultation on this problem.

As an additional approach to the subject of air pollution the Commission on Public Health invited a representative of the Commission on Convention Arrangements to one of its meetings and proposed that the subject of medical aspects of air pollution be covered in the program of the 1971 convention. D. S. O. Waife said he would propose at the next meeting of the Commission on Convention Arrangements that a morning or afternoon session be devoted to the subject of medical aspects of air pollution. D. Waife was also informed that at a recent regional public health meeting, there had been an excellent presentation of the venereal disease problem and that such a presentation would be desirable to include in the 1971 meeting of the Indiana State Medical Association.

Considerable time was spent at two of the meetings of the commission discussing two proposed pieces of legislation. One, on the matter of requiring laboratories who do venereal disease testing to report the results to the State Board of Health which would, in turn, notify the local health department and they, in turn, would contact the doctor and alert him to the fact that he had a positive case and see if he wished assistance in the epidemiology of the case. The other proposed legislation would authorize local boards of health to employ attorneys and provide funds in their budgets for the payment of these attorneys. The chairman of the commission was directed to present these legislative proposals to the Board of Trustees requesting their referral to the Commission on Legislation. These proposals for legislation were approved by the Board of Trustees at its meeting on June 14.

As directed by the House of Delegates, the commission discussed the Indiana State Medical Association Resolution 69-11 and House Enrolled Act 1290 dealing with physical examinations and testing for tuberculosis of all school employees. After much discussion and thoughtful consideration of the issue, the commission recommends that the word "physical" be eliminated from line 10 of House Enrolled Act 1290 and the Board of Trustees were so notified.

The commission discussed the status of the curriculum on public health in the Indiana University School of Medicine. The chairman was requested to communicate with the Dean of the medical school and inquire as to the curriculum on public health. It was further recommended that the dean of the Indiana University School of Medicine be invited to one of the commission meetings.

The commission discussed the teaching of venereal disease in teachers' colleges. It was decided that the chairman would correspond with members of the committee which has the responsibility of making recommendations concerning instruction in teachers' colleges and that this committee would be informed that the subject had been discussed and that the commission is anxious to support any activities on their part which increases specific knowledge of candidates for teaching degrees in health as far as venereal disease, in its entire application, is concerned.

The Board of Trustees referred to the Commission on Public Health Resolution 69-37 introduced by the Owen-Monroe County Medical Society concerning teacher certification for health education. The Commission on Public Health recommends that the Board of Trustees shall endeavor with appropriate educators' associations to change the requirements for certification so that a teacher will receive proper preparation for instructing in health education.

The Director of the Tuberculosis Division of the Indiana State Board of Health, Dr. Russell S. Henry, requested approval by the Commission on Public Health of a new approach to the eradication of tuberculosis which the Indiana State Board of Health is in the process of implementing as follows:

It is recommended that the following approach to tuberculosis eradication in Indiana by the Tuberculosis Section of the Indiana State Board of Health.

First Priority:

That all active cases be under drug therapy, isolated if an open case and all close contacts be examined. A tuberculin test should be had at least ninety (90) days after the contact is broken and all reactors be treated prophylactically for one year;

Second priority:

That all previously known cases of reinfection type of tuberculosis be examined as to their present status. Those cases that have been known to have inactive disease and are found to be still inactive at the time of the re-examination and have reliably proved they have had adequate drug therapy to be discharged with no further follow-up;

That all patients who have never been treated with anti-tuberculosis drugs and those who have had less than one year drug treatment as well as new active cases be given at least one year of drug treatment, after which time they will be discharged with no further follow-up, provided the cases are declared inactive at the end of the one or two-year treatment;

The determination of what constitutes adequate drug treatment is to be determined by the examining physician. There are several types of cases to consider. What is considered to be adequate drug treatment in one type of case will not be considered adequate in another type of case. Examples:

1. A case of over five years inactivity,

still inactive and never been treated, one year of I.N.H. is considered sufficient.
2. Any case who was treated with I.N.H. during the active stage and who converted to negative sputum in two to three months with corresponding chest x-ray improvement, one year of I.N.H. is considered sufficient.
3. Any case that failed to convert to negative sputum in three months, thereby requiring multiple drug therapy, must be treated with proper multiple drugs for a period of not less than two years.

The above covers the old inactive cases that had single drug treatment. New cases starting treatment within the past two years and some older cases have been on multiple drug therapy or at least should have been. In these cases, if the chest x-ray improved and the sputum converted to negative within two to three months, one year of treatment will suffice. Those who converted after three months should be on effective drug therapy for the full two years.

Third priority:

That all new school enterers in the first and kindergarten grades be tuberculin tested and all positive reactors treated for one year with I.N.H. Also, that all close associates of the positive reactors be examined to find the possible source case and that other children in the family (if any) also be tuberculin tested. Any other positive reactors in the home to be treated for one year with I.N.H.;

That children in grades over the first year who are positive reactors be treated for one year with I.N.H. with no follow-up of their associates;

That all close associates of positive reactors under five years of age be examined as possible source case as well as tuberculin testing all other children in the family (if any) and the positive reactors treated for one year with I.N.H.;

That all recent converters be treated with I.N.H. for one year with no follow-up of associates if the reactor is over six years of age.

This new approach is endorsed by the Commission on Public Health and it is recommended that the Board of Trustees approve this change.

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PAUL SPARKS, M.D.
WYANT J. SHIVELY, M.D.
EARLE U. ROBINSON, M.D.
DON C. FIELDS, M.D.

Voluntary Health Agencies

The Commission on Voluntary Health Agencies was constituted by the following members:

(1st Distr.) Albert Ritz, Evansville
(2nd Distr.) Robert H. Rang, Washington
(3rd Distr.) T. A. Neathamer, Scottsburg
(4th Distr.) Harry R. Baxter, Seymour
(5th Distr.) William G. Bannon, Terre Haute
(6th Distr.) Wayne Endicott, Greenfield
(7th Distr.) Norman R. Booher, Indianapolis
(8th Distr.) Lowell W. Painter, Winchester
(9th Distr.) A. Earl Applegate, Frankfort
(10th Distr.) Walfred A. Nelson, Gary
(11th Distr.) Lloyd L. Hill, Peru
(12th Distr.) Richard Willard, Bluffton
(13th Distr.) Frank J. McGue, Michigan City
(At Large) M. O. Scamahorn, Pittsboro
(At Large) Charles Rushmore, Indianapolis
(At Large) Max Hoffman, Covington

The organizational meeting of the commission was held on Sunday, January 25, 1970, and the commission was notified that President Steen had appointed the chairmen of the commissions for the coming year and had appointed Dr. Norman R. Booher as chairman and Dr. Wayne Endicott as vice-chairman. The commission went on record as giving a vote of confidence to both Dr. Endicott and Dr. Booher and elected Dr. Charles Rushmore as secretary.

A large part of the first commission meeting was spent in orientation for the work for the year and considering the suggestions made by the president of the association and the Board of Trustees. Plans for the year were perfected as noted below in the activities of this commission.

One of the great problems presenting itself to the commission, as usual, was that of communication between the segments of the ISMA, the members of the state association and the lay public.

For this reason, the chairman was ordered to seek a meeting with the Commission on Public Information, which he did, as noted below.

The commission seriously considered the feasibility of the organization of a new Indiana Health Council and the chairman was ordered to create a special study committee for studying this problem.

As is customary, at its January meeting, at least one-half of this meeting was devoted to meeting with the executives and presidents of the voluntary health agencies of Indiana.

Represented at this meeting were: Indiana Heart Association; American Cancer Society, Indiana Division; Indiana Society for Crippled Children and Adults; Mental Health Association in Indiana; Indiana Tuberculosis Association; Indiana Society for Prevention of Blindness; Cystic Fibrosis; and United Cerebral Palsy.

As has become customary there was a very free discussion between the members of the commission and these groups and the commission was very pleased to have many expressions of obviously sincere satisfaction on the part of voluntary health agencies with the cooperation of the Indiana State Medical Association in programs involving them.

Together with these representatives of the voluntary health agencies a joint scientific meeting was planned for the fourth year, to be held as a part of the annual meeting of the Indiana Public Health Association on April 23, 1970. A joint committee between the commission and the agencies was appointed to work out the details of this program and obtain the speakers.

A special committee made up of two members of the commission and four representatives of the agencies was appointed to study the feasibility of the reformation of the Indiana Health Council.

In the interval between the first meeting in January and the second meeting on April 23, 1970, the members of the commission spent a great deal of time on their assignments as liaison representatives to two or more of the voluntary agencies, receiving their reports, studying them, and making recommendations on the reports to the commission.

The joint meeting with the Indiana Public Health Association and the Indiana Tuberculosis Association, held on April 23, produced a very good program which fit in the general scheme of the meeting, which was, "The Place of Allied Help in the Future Delivery of Health Care." The commission felt that this meeting was an excellent springboard not only in the scientific material presented, which was apropos, but most important from the point of view of public relations of the Indiana State Medical Association.

At the conclusion of the scientfic program on April 23, the commission held its second regular meeting of the year.

At this meeting the first decision was that a revision of the Indiana Health Coun-

cil should be approached with caution and that the existing health council should be strengthened to provide more necessary coordination and that the Indiana Public Health Association be encouraged to play a greater coordinated role in the work of the present Indiana Health Council.

At this meeting the remainder of the questionnaires of the various voluntary health agencies having statewide programs were reviewed and the following organizations approved for the current year as having met the criteria of the Indiana State Medical Association: American Cancer Society, Indiana Division; The Arthritis Foundation; Indiana Society for Prevention of Blindness; Indiana Society for Crippled Children and Adults, Inc.; Central Indiana Chapter, National Cystic Fibrosis Research Foundation; Tri-State Epilepsy Association, Inc.; Indiana Heart Association; Indiana Association for Mental Health; Indiana Chapter, National Multiple Sclerosis Society; Indiana Tuberculosis Association; United Cerebral Palsy of Indiana, Inc.

One of the most momentous things to happen to the commission during the year was the reception of the legal opinion of the attorneys for the Indiana State Medical Association, which had been requested from the Board of Trustees, asking the legal position of the ISMA to change the word used within the program of the voluntary health agencies from "recognized" to "approved" and to consider at the same time the legal position in relation to dissemination of information available to this commission to persons other than members of the Indiana State Medical Association. This legal opinion was received by the commission under date of March 17, 1970. Permission was given to change the verb from "recognized" to "approved" and to disseminate the information to lay sources under certain definite restrictions. These restrictions include the fact that it be noted the approval is definitely by the Indiana State Medical Association, through its Commission on Voluntary Health Agencies; that the criteria be clearly stated; that we should not list any voluntary health agency which has failed to meet the criteria and that each agency listed on the published information shall have given permission to have its name so listed.

In line with the legal decision, the commission has obtained, in writing, the desire of each of the voluntary health agencies on the approved list to change the word from "recognized" to "approved" and permission to have their name included with the others on the approved list distributed to general sources of information.

At the April meeting of the Board of Trustees, the chairman of the commission presented this information to the Board, who approved the use of the word "approved" rather than "recognized" and the publication of the placards, as published in other years.

At the June 14 meeting of the Board of Trustees, the chairman presented the following list as being the list to whom the approved agency list would be disseminated:

Indiana State Chamber of Commerce; local Chambers of Commerce; Junior Chambers of Commerce; State Better Business Bureau; membership, Indiana State Medical Association; membership, all approved agencies (also all unapproved agencies); daily newspapers, weekly newspapers, radio, television (statewide); Indiana Public Health Association; Indiana Health Council; Woman's Auxiliary, Indiana State Medical Association; Indiana Dental Association; Indiana State Board of Health; Headquarters, Regional Medical Programs; Indiana Health Careers, Incorporated; Indiana Pharmaceutical Association; Indiana Nurses Association; Community Service Council-Indianapolis; mayors—all Indiana cities; all state representatives and senators; governor; county health officers; all recognized comprehensive health planning organizations; Indiana Manufacturers Association; labor unions; school systems; service organizations—Lions, Rotary, Kiwanis, Optimists, Exchange; fraternal organizations—Elks, Moose, Masonic; veterans' organizations; state women's clubs; Home Demonstration Clubs; universities; Farm Bureau.

The Board of Trustees approved this list and also the printing of the placards on 8½ x 11 stock and at this time the cost was quoted to the Board as approximately eight dollars per thousand.

It also approved the distribution to the membership of the state medical Association, similar to that of the past—either by inclusion in the News Flash, or other information going out for distribution, or by the field secretaries.

The following letter was presented to the Board of Trustees as being the covering letter which should be sent out, together with the placards, which would list the names of the agencies. This letter was approved, in principle, with the understanding that minor changes might be made:

"The members of the commission are happy to report to the House of Delegates that we feel the development and continuation of the program of the commission this year reached an epic in development because for the first time we will now be able to give to the public at large accurate information on the voluntary health agencies that have met the criteria of this association.

"You should be aware of these voluntary health agencies at a time when their role in medicine should be stronger than ever."

The commission requests the approval of the House of Delegates of this program and its permission to follow this program in a similar vein next year.

The members of the commission have spent far more hours on the work of this commission than this report can reflect.

The commission is very grateful for the cooperation of the members of the Commission on Public Information of the ISMA who have assisted in procuring the legal opinion and who have assisted us in working towards wider dissemination of the information and for greater participation on the part of the membership of the Indiana State Medical Association; also for the thousands of volunteers who devote their time to the health interests of the general public.

The commission wants to again publicly acknowledge the very fine executive work of Mr. Kenneth Bush, who has carried a heavy load of the work of this commission; we are also grateful to Mr. James Waggener and to the officers of this association for their unusually fine cooperation this year, and we remain very grateful to Miss Eleanor Chapple, who has been our faithful secretary since the commission was organized.

NORMAN R. BOOHER, M.D.,
Chairman

Medical Economics and Insurance

During the years 1969-1970, the Commission on Medical Economics and Insurance of Indiana State Medical Association continued its slow progress toward the goal of providing a package of benefits, at group rates, for all Indiana State Medical Association members.

The program of disability insurance is growing, in participation and in stability. It is now available even to members with previous medical problems. The commission recently introduced the group term life insurance plan to the membership; its rates are very attractive, and the acceptance by membership has been good.

The possibility of providing group "malpractice" protection has intrigued the commission for several years, and this year the membership was surveyed by letter. Happily, 53% of you replied telling us your experience and conclusions concerning liability insurance. We know now that many of you liked the idea of group coverage and are accepting the concept of peer review to ensure it. We also know that most

of you are happy with your present coverage. The data are being examined in many ways, and we hope to offer a detailed analysis in this *Journal* in the near future.

The status of retirement plans and the benefits and pitfalls of incorporation are continually reviewed. They provided the background for the panel discussion on just such projects at the 1969 ISMA convention.

The commission thanks you for your cooperation and welcomes your suggestions and criticism.

THOMAS J. CONWAY, M.D., *Chairman*
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WILLARD BARNHART, M.D.
THOMAS G. HAMILTON, M.D.

Medical Education and Licensure

The Commission on Medical Education and Licensure met on January 11, 1970, April 9, 1970, June 14, 1970 and August 16, 1970. In addition to the regular commission members in attendance, Dr. Steven Beering attended each meeting as a guest and consultant regarding several problems. A SAMA representative also attended some of the meetings. Other guests and consultants invited to assist the commission in its deliberations included Dr. Robert Stonehill, Dr. Raymond Murray, Dr. Jerry Royer and Mr. Don Dian. Areas of concern and problems assigned to the commission for study and recommendation were:

1. Postgraduate medical education in Indiana.
2. The Indiana statewide medical education system.
3. Licensure of foreign medical graduates.
4. The preceptor program of ISMA and Indiana University School of Medicine.
5. Speakers Bureau.
6. MECO—Medical Education and Community Orientation.
7. Physicians' assistants.

1. POSTGRADUATE MEDICAL EDUCATION IN INDIANA. Study has been made to encourage increased attendance to postgraduate programs. In this effort five programs will be given in hospitals in communities over the next year. The use of resort areas with the families being invited is also under consideration. The number of hours available in Indiana in 1969, as compared to the surrounding states, is 759 hours with a range of from 257½ hours in Kentucky to 1,326 hours in Pennsylvania. The schedule of programs has been made available by general mailing and is to be published in *The Journal* of the Indiana State Medical Association.

Compulsory postgraduate medical education for ISMA membership is being studied by the commission. Material from Oregon has been requested and circulated to the commission for study before definite recommendations are made by the commission.

2. INDIANA STATEWIDE MEDICAL EDUCATIONAL SYSTEM. The Commission followed the progress of the Governor's Commission on Medical Education and studied its resolution. The commission supports the plan presented by this resolution and recommends the full support of the ISMA to get legislative approval and enabling legislation for this resolution as well as to support the Indiana University School of Medicine in its implementation.

3. LICENSURE OF FOREIGN MEDICAL GRADUATES. Because of the critical situation existing in Indiana and especially some areas regarding available physicians, foreign medical graduate licensing was studied. Two areas were considered: (a) The temporary licensure of foreign medical graduates for institutional practice under supervision, (b) Licensure by endorsement of foreign medical graduates on the same criteria as U. S. graduates, eliminating the three-year residency requirement in the state of licensure. This was approved by the commission and forwarded to the ISMA Board of Trustees where it was defeated. The subject was again discussed and again the commission recommended that the Board of Trustees of ISMA recommend to the Indiana Board of Medical Registration and Examination that the three-year residency requirement after licensure in another state prior to Indiana licensure by endorsement be removed.

4. PRECEPTOR PROGRAM. The commission studied the possibility of recognition of preceptors both by presentation of certificates of appreciation and possibly by medical school faculty appointment. Faculty appointments will be delayed until the development of the new department of family practice at Indiana University School of Medicine. Workshops and training seminars for general practice preceptors are being considered with the help of the students. A list of 51 students was given to the commission. This is 11 more than last year.

5. SPEAKERS BUREAU. The list of speakers in the ISMA Speakers Bureau was completed and will be maintained in the headquarters office of the ISMA. It is to be published in *The Journal* of the ISMA. The list is also to be sent to hospitals having medical education programs. Arrangements for expenses and/or stipends for the speaker are to be made by the speaker and the agency asking for his service.

6. MEDICAL EDUCATION AND COMMUNITY ORIENTATION PROGRAM OF SAMA (MECO). This program is one which is sponsored by SAMA and provides that medical students are given educational opportunities at pre-clinical levels or before the freshman year, as well as clinical, in community hospitals. The students work under the supervision of a specific doctor and are paid by the hospital. The commission recommended this program be approved in principle for Indiana and referred it back to the ISMA Executive Committee.

7. PHYSICIAN ASSISTANT PROGRAM. Much time was spent in studying the Physician Assistant Program—the needs, utilization, and allied problems. Several consultants testified regarding these programs. Much material was sent to the commission members for study. The commission is well informed regarding the problems and is continuing its study but is at this time not ready to make recommendations relative to programs in Indiana. Two major problems are present in Indiana: (a) What to do about the trained assistants coming into the state and (b) what to do about developing physicians' assistant training programs in Indiana.

In relation to the first problem, the commission recommended that Indiana not license physicians' assistants but rather recommend they be certified and registered and that the Medical Practice Act of Indiana be modified to permit physicians' assistants to provide their services under the supervision of physicians licensed to practice medicine in Indiana.

The commission has no recommendations regarding the second problem. In view of the many problems, the lack of uniformity of entrance requirement, curriculum and educational requirements, type of certification and degree, and the lack of guidelines regarding the patients' relationships, the hospital relationships and the M.D.s relationships to the new health-care workers; and in the absence of AMA

guidelines in these areas, the commission has no recommendation. It will continue to gather information and statistics prior to a decision. A poll is to be made from the specialty groups in Indiana as well as the individual physicians in order to establish needs, job descriptions and other pertinent information.

I, as chairman, wish to thank the ISMA staff for their help with the many duties related to this commission. I also wish to thank each commission member who worked so hard on this very important commission. The help of the consultants and guests has also been invaluable and is greatly appreciated.

FRANKLIN A. BRYAN, M.D.,
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MERRITT O. ALCORN, M.D.
GLENN W. IRWIN, JR., M.D.
(*ex-officio*)

Special Activities

During the 1969-70 year, the Special Activities Commission concerned itself with the problems of alcoholism, drug addiction, incompetent physicians and a recurring problem with orientation of new members to the Indiana State Medical Association. Numerous other small problems were brought to our commission's attention and were suitably solved with the situations corrected.

The commission studied the trials of alcoholism and adopted the recommendations which were developed by Dr. Hanus J. Grosz of Indianapolis. They were as follows:

1. That the Indiana State Medical Association declare its intent to actively support and implement the 1956 and 1966 resolutions on alcoholism passed by the AMA House of Delegates.

2. That the Indiana State Medical Association establish a Commission on Alcoholism and Drug Addiction.

3. That the Indiana State Medical Association encourage local hospitals to set up facilities for admission treatment and referral of alcoholics (as recommended by the AMA, American Hospital Association, and American Psychiatric Association) and postgraduate refresher courses on alcoholism and drug addiction.

4. That the Indiana State Medical Association recommend to the state legislature to appropriate more funds for working in the field of alcoholism and funds for work in the field of drug addiction.

5. That the Indiana State Medical Association recommend that the Indiana state mental hospitals set up an alcoholism and drug addiction treatment unit.

The commission considered the problem of physicians who are not practicing the brand of medicine that is considered adequate in the state of Indiana. It was reported that a number of physicians in the state were requesting power be placed in a judiciary committee who could recommend to the state licensure, withdrawal of license and registration from physicians who obviously were not practicing proper medicine. It was pointed out that at present, medical societies have little or no vehicles with which to "wash their own linens" with physicians who are not competent or who are practicing unethical medicine. After much debate, the commission recommended to the Board of Trustees of the Indiana State Medical Association the formation of a judiciary committee for the purpose of being empowered by the state of Indiana to remove or suspend an M.D.'s license with just cause.

During the first two years of the previously adopted orientation program, both interest and attendance were poor despite the fact that all new members were requested to attend (both a state orientation and a district orientation program) once during the first two years of practice, with all expenses paid. Apathy reigned supreme and only approximately 15% attended. Obviously the program was dying on the vine. The need for an orientation program to encourage ISMA members to know about and be interested in their state organization still existed. It was also apparent that a new approach was necessary.

An audio-visual presentation was discussed. It was felt if such a program could be developed, it could be shown to medical students, district societies, county societies or any other feasible medical gathering. Mr. John Walters. ISMA field secretary, was requested to develop a sample program, which he did very expertly. By using transparencies with an overhead projector and a prepared script, he gave a good and attention-getting presentation. Two members of the commission met with Dr. Glenn Irwin, who felt such a presentation could and should be made available to the students. It could also even be shown on the school's statewide closed circuit television system which is now operational.

Another suggestion was the use of a loose-leaf binder with a tape recorder, both of which would be given each new member. They then could be used at his home for not only orientation to ISMA but also for other information which would help him start his medical practice.

The Special Activities Commission recommends that the Board of Trustees appropriate Mr. Walters funds for a pilot program which he will present in the fall to the Board and to the commission members.

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PETER E. GUTIERREZ, M.D.
ROBERT P. ACHER, M.D.
HANUS J. GROSZ, M.D.

Aging

The Commission on Aging met on three occasions in 1970, January 11th, March 12th and July 12th. The first meeting was basically an organizational meeting and the outlining of the problems to be discussed during the year.

The general plan was to follow-up the projects of the past year, and encourage the implementation of the resolutions that were passed by the House of Delegates.

There was much discussion during the year on the methods of implementation of the medical care in the nursing homes and continued treatment homes. Many of the members of the commission, and presumably members of the ISMA, have many questions regarding the Certification for Continued Treatment under Medicare. It was arranged to have Mr. Kilborn and Mr. VanDyke meet with the commission to try to answer these questions. A long discussion ensued on the problems of how a person is certified and under what standards the patient is certified.

The major answer from the Blue Cross was that SCA has tightened up the money and because of this, patients are not being certified. We were not able to get a specific list of criteria that are necessarily fulfilled before a person can be certified. Either this is not known or it is not being revealed.

Another project that was discussed at some length was the problem of training someone to take care of the chronically ill person who is home-bound. This problem

is always acute. Blue Cross was asked if there are possibilities of funding of home care through Medicare or Medicaid. We were told it would be looked into.

Again we discussed at some length the 75th percentile and have the same answers that have been around for a long time; nothing new was gained by this.

The commission has presented two resolutions to the 1970 House of Delegates. One of these, regarding more specific policy changes in Social Security, we feel would be of benefit to the aged, and by using the policy of partial disability in addition to total disability, we believe this policy would be of major benefit to the aged, as well as people who are approaching retirement.

The second one is aimed at broadening the facilities at hand to give a more balanced, and hopefully more economical, way of taking care of aged patients by the addition of home-bound care. We believe that it is more economical to treat people in their own home than in hospitals, continued treatment or nursing home facilities.

The Commission on Aging discussed at great length the methods by which the Indiana State Medical Association can deal more specifically, with more strength, in the areas of aging. It is our opinion that in the coming years we should broaden our base, and align ourselves with all the groups of both private citizens, as well as governmental agencies, that are interested in problems of the aging.

Since our knowledge is mainly medical and our specific interest is basically limited to the medical treatment of the aged, we should attempt to add this knowledge to those that are interested in housing, socialization and finance, etc. This approach may give a much better understanding and therefore much better opportunity to plan necessary changes in programs for the aged.

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THOMAS A. ELLIOTT, M.D.
DANIEL BERNOSKE, M.D.

Resolutions

Amendments to the Constitution to be Voted on at South Bend Session, 1970

At the 1969 annual convention at Indianapolis, the House of Delegates adopted the report of the Reference Committee on Amendments to the Constitution and By-laws, in which the Reference Committee recommended for adoption the following amendments to the Constitution:

Be It Resolved that Article IV, of the Constitution be amended by adding a Section 3, which shall read as follows:

"Sec. 3.—Interns and Residents. Interns and Residents who hold membership in the Indiana State Medical Association shall have all the rights and privileges of this Association except the right to hold office and to vote."

Be It Further Resolved, that Article IV be further amended by renumbering the present Section 3 to Section 4; by renumbering the present Section 4 to Section 5; by renumbering the present Section 5 to Section 6; by renumbering the present Section 6 to Section 7 and renumbering the present Section 7 to Section 8.

Be It Further Resolved, that Article IV, the present Section 7 be renumbered Section 8 and amended to read as follows: "Sec. 8.—Rights and Privileges of Members—Active members, senior members and disabled members shall have the same rights and privileges except as follows:" (the balance of this Section to remain the same).

Be It Resolved, that Article XI, Sec. a. of the Constitution be amended to read as follows: "a. Membership dues to be collected may be collected by the Indiana State Medical Association or by the component county societies in connection with the dues for such component societies. The amount of dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates."

Report of Board of Trustees

Report: A
(A-70)

Subject: Resolution 69-12—INSURED AMBULATORY DIAGNOSTIC BENEFITS

Presented by: Peter R. Petrich, chairman, Board of Trustees

Referred to: REFERENCE COMMITTEE #2

Resolution 69-12 was referred to the Board of Trustees last year by the House of Delegates. The Board's Liaison Committee with Blue Cross discussed this resolution at length with the Medical Advisory Committee of Blue Cross earlier this year.

It was generally agreed that such outpatient diagnostic studies would have to be performed in facilities which were approved by the hospital medical staff which was accepting these reports as a part of their medical records. Secondly, it was agreed that the outpatient facility performing the examination must be licensed by the Indiana State Board of Health. Reports from unlicensed facilities could not be accepted.

The mode of payment for these services presents serious problems. Blue Cross has adopted the concept of "pre-admission" testing as long as these services are performed in hospital departments. Blue Cross is not allowed to pay for physicians' service on outpatients. The Board favors continuation of this policy. Currently, Blue Shield does not cover benefits for outpatient *pre-admission* laboratory or x-ray studies.

It seems that some sort of plan could be worked out between Blue Shield and Blue Cross to pay for pre-admission testing done outside of hospital facilities. This should result in a significant lowering of the overall cost of hospitalization for the patient. The problem was then taken up at a joint meeting of the Executive Committees of Blue Shield and Blue Cross on June 17, 1970. The subject was in turn referred to the staff of Blue Cross-Blue Shield, and a report from them is to be received by no later than October 1, 1970.

Therefore, the Board of Trustees of the ISMA strongly recommends that hospital staffs and Blue Shield and Blue Cross be urged to recognize testing done outside of outpatient facilities for pre-admission and that the Board of Trustees is hereby requested to work toward accomplishing that goal.

Report of Board of Trustees

Report: B
(A-70)

Subject: Resolution 69-14—MEDICAL EDUCATION

Presented by: Peter R. Petrich, chairman, Board of Trustees

Referred to: REFERENCE COMMITTEE #2

The Indiana State Medical Association does support and has in the past supported strongly the Indiana Plan for Medical Education in the state of Indiana. We have unstintingly cooperated with the Indiana University School of Medicine's administrative officers to support and help them in their present and future needs for planning for medicine in the state of Indiana. Many of our men in the cooperating areas, along with the directors of medical education, both full and part-time, have worked cooperatively with the faculty advisory groups from the Indiana University Medical School in sponsoring medical education on a local level. The Board Liaison Committee has relatively continuing informal contact with the Indiana University faculty committee.

Future activities have been discussed and since they are only in the planning stage, no definitive action can be taken in these areas; however, in the area of curriculum in the university, changes have been made with the aim in mind of providing to the state of Indiana more interns and residents and to help in several localities in the state of Indiana to secure additional physicians in the future by encouraging our graduates to remain in Indiana. The local areas will now be the site of education on an elective basis in the senior year for the entire student body in Indiana University. The elective areas will be in the several specialties as well as general practice. A change in curriculum, also, brings about in university structure a Department of General Practice or Family Medicine.

The program has begun and we are building toward what we hope will be a broad usage. As in all plans, there may be several years of time involved before fruition in the form of actual increase in the numbers of doctors practicing in Indiana occurs, especially in the area of family medicine. However, the Board of Trustees of the Indiana State Medical Association feels very strongly that the Indiana plan is the plan that is to be preferred above any and all other plans for medical education in Indiana.

The Board of Trustees urges that all members of the House of Delegates as well as members of this association, continue to support the Indiana Plan for Medical Education and work toward its further implementation.

Report of Board of Trustees

Report: C
(A-70)

Subject: Resolution 69-16—HEALTH MANPOWER

Presented by: Peter R. Petrich, chairman, Board of Trustees

Referred to: REFERENCE COMMITTEE #2

This is not a definitive report on Resolution 69-16, referred by the House to the Board of Trustees. It is more of a status report of the various activities which have taken place and are taking place in the specific areas mentioned in the resolution.

The question of providing adequate

health manpower is an overwhelming one, as everyone knows. It is felt that the Indiana State Medical Association Commission on Medical Education and Licensure should undertake a more active and definitive role in planning of training programs, etc., that might be involved in the acquisition of health manpower personnel in Indiana. The Board of Trustees should be involved in directional planning but should act only upon whatever activities the Commission on Medical Education and Licensure should propose; however, neither the Board of Trustees nor the Indiana State Medical Association should become directly involved in the educational processes involved in the training of ancillary medical personnel. This type of ancillary help will be featured in the care of various segments of the population as proposed in national health care systems under discussion.

The present status of physicians' assistants is as follows: There is a pilot program being undertaken at the Regenstrief Institute, under the direction of Dr. Raymond Murray, utilizing as a core group registered nurses who are actually capable of extending their ability above and beyond the clinical experience that is theirs now. There have been some conversations with the dean of the university toward the establishment of a less complicated physicians' assistant program in the matter of training. Throughout the next year further discussion will take place and the method or plan of operation might be concluded and a trial training program instituted. In the discussion it was felt that the legal and professional status of physicians' assistants and/or any allied health personnel should be not one of licensure, but rather one of certification, since all of their activities should be and must be under the responsibility and direct supervision of practicing physicians.

The allied health personnel training programs are very adequate in some cases and in others need some realignment, perhaps strengthening, in various areas. It may very well be over a period of time that some of these particular specialty training groups, such as radiological technicians and laboratory technicians, will be divided in several sections or responsibility areas so that rather than all conforming to the current assistant's programs, training might be limited in some areas to provide technicians who are able to do only specific tasks. This could shorten training time for delivering certain health services and still provide exceptionally trained technicians via fuller programs.

These and many other things are problems in training and supplying of allied health personnel, including physicians' assistants. It is a program which is under the supervision of the Indiana State Medical Association, through the Board of Trustees, the commissions and committees, and one which will continue to be studied and scrutinized in the future.

The Board of Trustees recommends that the House go on record supporting the fact that ISMA should, through its Commission on Medical Education and Licensure, set forth the requirements for an appropriate curriculum, recommend the time period of training, recommend the pre-admission requirements for people admitted to the paramedical classes program and strongly urge every state university in Indiana to become involved, along with the local hospital in that area, in training allied health personnel.

Furthermore, we recommend that the Commission on Medical Education and Licensure vigorously work with interested state universities to implement the program and to support legislation accomplishing these goals.

Report of Board of Trustees

Report: E
(A-70)

Subject: Resolution 69-13—PHYSICIAN SHORTAGE
Resolution 69-15—DELIVERY OF HEALTH CARE

Presented by: Peter R. Petrich, M.D., chairman, Board of Trustees

Referred to: REFERENCE COMMITTEE #2

In considering Resolution 69-13 and 69-15, the Board which received a status report of the Joint Ad Hoc Committee on Medical Education, recognizes that the statewide medical education program will help considerably in increasing medical student enrollment. However, it is not certain that such programming is the answer from the long-term point of view.

Such a program, however, might be instrumental in developing, over the years, a nucleus of instructors who could meet faculty assignments for a future second medical school, which would be a more satisfactory method of training additional physicians.

Additionally, the Indiana State Medical Association should strive to *assist in every way possible in obtaining funds through appropriate legislation and other activities for* affiliated hospitals in the state associated with the medical education plan. Many practicing physicians are involved in teaching in the hospitals and are, consequently, compelled to partially neglect their practices. These physicians should be compensated for their effort in the same manner as instructors at the Indiana University School of Medicine.

The committee further reported in its year-long study that there are a few more physicians each year entering family practice. Every resident and internship opening at the Methodist Hospital, Indianapolis, was filled this past year for the first time.

The committee has also endorsed the development of a Chair for Family Practice at the Indiana University School of Medicine.

The well-organized nursing profession in Indiana should be additionally developed as allied medical personnel assigned to assume some of the physician's responsibilities under his supervision. Nurses providing such service could actually be utilized in small communities to function in this capacity with direct liaison with a local practitioner or clinic.

Technicians and corpsmen returning from service could also be trained to fulfill similar responsibilities. Medical-legal aspects of such an approach should be considered in depth as well as the type of registration or licensure for such personnel.

Group practice by physicians in rural communities was cited as an inducement to physicians to practice in smaller communities. The Tell City Clinic plan was specifically pinpointed, as an example.

Report of Board of Trustees

Report: F
(A-70)

Subject: Resolution 69-18—CONTINUING MEDICAL EDUCATION

Presented by: Peter R. Petrich, M.D., chairman, Board of Trustees

Referred to: REFERENCE COMMITTEE #2

The Board of Trustees, concerning the matter of methods of providing continued certified education including self assessment programs, recognizes that there is value in developing residency programs in hospitals to which practicing physicians could return on a periodic basis for specialized training in any area.

This could be for a period of two or four weeks on a four month or six months' basis. This, of course, would be particularly applicable for a group of physicians who practice together.

Efforts should be made to establish such residencies on a full time, dynamic basis which would fulfill the recommendation that Indiana physicians possess the most modern medical knowledge to deliver the highest quality medical care.

Report of Board of Trustees

Report: H
(A-70)

Subject: Resolution 69-20—COLLEGE HEALTH FORMS

Presented by: Peter R. Petrich, chairman, Board of Trustees

Referred to: REFERENCE COMMITTEE #2

A committee of the Board of Trustees of the Indiana State Medical Association has met with the college health physicians in an attempt to obtain a unified health examination form—a form which will be easily completed and quickly interpreted.

There are several reasons why a new form cannot be instituted immediately:

1. Each university has particular mechanical equipment to process their forms—this equipment is too expensive to be changed immediately.
2. The health physicians in the various universities tend to stress different portions of the examination (as physicians in private practice tend to do also).
3. Purdue University is not requiring, at the present time, a health examination. They strongly urge and feel that it is quite valid and good, but, they have had difficulty in enforcing the examination.

Members of the medical staff of the various universities have been very cooperative, particularly Dr. John Miller, Indiana University, who is chairman of the Committee on College Health Physicians. In the very near future Dr. John Miller plans to spend a period of time studying how the computer may be utilized in assisting university physicians in the health study of their students; through this a good, comprehensive, universal, preadmission health form may be obtained.

Report of Board of Trustees

Report I
(A-70)

Subject: CONVENTION SITES AND FACILITY REQUIREMENTS

Presented by: Peter R. Petrich, chairman, Board of Trustees

Referred to: REFERENCE COMMITTEE #2

In the past, convention sites have been named by the House of Delegates five years in advance. Recently, much interest has been shown by various component medical societies to host the annual meetings in various parts of the state.

In an effort to cooperate with the local medical societies, the Board of Trustees would like to present to the association what it believes are the minimum facilities that are necessary to host the annual convention of the Indiana State Medical Association. In this manner the component medical societies can determine well in advance whether their city meets the minimum requirements or not. The following represents the minimum facilities required to host the convention:

Total Registration—1500 to 2000

1. Facilities located in the same building
   (a). Exhibit area—20,000 to 25,000 square feet
   (b). Minimum of 15 meeting rooms
   Seating from 30 to 80 for meals
   Auditorium space to accommodate minimum of 500
   This room should have a stage; public address facility; projection facility; ample ventilation and cooling facility
   Space for storage of exhibit crates
   Press room and room for headquarters office and work room for headquarters staff
   Adequate parking
2. Facilities not necessarily in same building as exhibits
   (a). 500 to 600 class A hotel rooms
   (b). Banquet space to feed 600—or if luncheon instead of banquet, room to serve 1,000
   (c). Theatre for entertainment—seating 600 minimum
   (d). Gaslight type program requiring a facility having a large room, plus three or four smaller rooms to accommodate from 600 to 1,000 people for drinks, food and entertainment
   (e). Facilities for meeting of Executive Committee and luncheon (15 people)
   (f). Facilities for breakfast and meetings of Board of Trustees (50 people)
   (g). Golf course
   (h). The city should be easily accessible by air and other transportation
   (i). Good warehouse and cartage facilities

The cost of the convention facilities, that is, the items listed "in the same building" should, insofar as possible, be defrayed by the income obtained from the sale of exhibits and tickets for the various dining or entertainment functions.

Societies interested in hosting the annual convention of the association should extend an invitation to hold the convention in their city to the Board of Trustees by June 1st of each year for the meeting to be held five years hence. The Board shall study all proposals and make their recommendation or recommendations to the House of Delegates for the final decision on the selection of a site.

Societies hosting the convention will be expected to establish committees designated by the state association and whose functions will be to carry out only these matters specifically referred to the local committee by the Commission on Convention Arrangements.

Resolution No. 70-1

Introduced by: BOARD OF TRUSTEES

Subject: DISCONTINUANCE OF MANDATORY ORIENTATION PROGRAM

Referred to: REFERENCE COMMITTEE #5

WHEREAS, the Board of Trustees has been charged with implementing our orientation program for new members, and,

WHEREAS, the Board has worked diligently to accomplish the mandate of the House of Delegates, and,

WHEREAS, the attendance at these meetings has been less than five percent of our new members and since no punitive action has been provided to force compliance with the resolution passed by the House of Delegates in 1967,

NOW, THEREFORE, BE IT RESOLVED, that this House rescind its previous action thereby abolishing the orientation program but strongly urge that all county societies establish an orientation program suited to their individual needs, and,

BE IT FURTHER RESOLVED, that Section 1 of Chapter 1 of the Bylaws be deleted, and that present Sec. 2., Sec. 3., Sec. 4., and Sec. 5., be renumbered Sec. 1., Sec. 2., Sec. 3. and Sec. 4.

Resolution No. 70-2

Introduced by: EXECUTIVE COMMITTEE

Subject: REDUCTION OF NUMBER OF RESIDENCY PROGRAMS

Referred to: REFERENCE COMMITTEE #3

WHEREAS, there is a shortage of family practitioners in the United States, and,

WHEREAS, there are roughly four times as many approved residency positions as there are U. S. medical school graduates each year, and,

WHEREAS, the solution to the health care needs of our citizens is not to turn out more specialists and fewer family practitioners, and,

WHEREAS, with the cooperation of the American Academy of General Practice, residency programs are being developed in

family practice.

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association instruct its delegates to the next American Medical Association Convention to introduce a resolution directing the AMA Council on Medical Education to formulate a program to decrease the number of approved residencies by roughly three-fourths, and,

BE IT FURTHER RESOLVED, that this same resolution will direct the Council on Medical Education to report back to the 1971 AMA House of Delegates as to what progress has been made in implementing the residency position reduction.

Resolution No. 70-3

Introduced by: FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY
Subject: STUDY DEVELOPMENT OF A RELATIVE VALUE SCHEDULE
Referred to: REFERENCE COMMITTEE #4

WHEREAS, a large percentage of payments for medical services are now being provided by third party mechanisms, prepaid medical insurance and governmental programs, and,

WHEREAS, there is considerable discussion between physicians and these payment mechanisms regarding establishment of fees, and,

WHEREAS, many physicians are now using California Relative Value Studies in basing their fee structures.

NOW, THEREFORE, BE IT RESOLVED, that the Board of Trustees of the Indiana State Medical Association instruct the appropriate commission or commissions to make a study of the applicability of the California Relative Value program or similar type relative value plan in the state of Indiana and report the results of the study, with recommendations, at the next annual meeting of the Indiana State Medical Association in October, 1971, for action by the House of Delegates.

Resolution No. 70-4

Introduced by: FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY
Subject: FEE NEGOTIATING MECHANISM
Referred to: REFERENCE COMMITTEE #4

WHEREAS, government and prepaid insurance mechanisms provide for usual, customary and reasonable payment for medical services in many programs, and,

WHEREAS, through edict of bureaucratic officialdom, payment has been restricted to the 75th percentile in Medicaid cases, and,

WHEREAS, no negotiating mechanism is presently available in the state of Indiana,

NOW, THEREFORE, BE IT RESOLVED, that the Board of Trustees of the Indiana State Medical Association appoint an appropriate commission or body to study this problem and submit to the next annual meeting recommendations for the formation of a suitable group to negotiate equitable payments in the future.

Resolution No. 70-5

Introduced by: DELAWARE-BLACKFORD COUNTY MEDICAL SOCIETY
Subject: OPPOSITION TO PLAN OF GOVERNOR'S COMMISSION ON MEDICAL EDUCATION
Referred to: REFERENCE COMMITTEE #3

WHEREAS, the Governor's Commission on Medical Education has recommended the utilization of seven small regional campuses to instruct the first and fourth year medical students, and,

WHEREAS, this plan would be difficult to implement, requiring many trained medical educators to instruct small groups of students in seven different areas, and would be difficult to achieve, and,

WHEREAS, it would dissuade better medical students from attending Indiana University Medical School,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association oppose this plan.

Resolution No. 70-6

Introduced by: CLARK COUNTY MEDICAL SOCIETY
Subject: UTILIZATION REVIEW
Referred to: REFERENCE COMMITTEE #4

WHEREAS, physicians are trained and are obligated to care for the ill in the best way they know how, and,

WHEREAS, the shortage of physicians is causing more and more of their time to be taken in the care of the sick, and,

WHEREAS, the duties of the physicians in the hospitals are requiring increasingly more time, and,

WHEREAS, most of these hours in the hospital are spent on endless committee meetings that the government is requiring, and,

WHEREAS, the Utilization Review Committee physicians are now being asked to police other doctor's patient charts as to the patient's need to be hospitalized or continued in the hospital, and,

WHEREAS, only the physician entering a patient into the hospital really knows the reasons for the admission, and,

WHEREAS, another physician cannot possibly ascertain from a chart whether a patient needs to be or not be in a hospital, and,

WHEREAS, the Medicaid and Medicare insurance intermediary is requiring such a program, and,

WHEREAS, the implementation of such a program will only bring about more bad publicity on the medical profession, and,

WHEREAS, the physicians of Indiana did not ask for such a program,

NOW, THEREFORE, BE IT RESOLVED, that the physicians of Indiana go on record as opposing the use of their peers to peruse the admissions of other physicians and that the Medicaid and Medicare intermediary do such police action themselves.

Resolution No. 70-7

Introduced by: DAVIESS-MARTIN COUNTY MEDICAL SOCIETY
Subject: REPEAL OF UNITED NATIONS CHARTER
Referred to: REFERENCE COMMITTEE #5

WHEREAS, the United Nations Charter was ratified by the United States Senate and President, July 28, 1945, after obtaining authority from a sufficient number of state legislatures, and,

WHEREAS, we have witnessed a steady disintegration of the principles upon which this nation was founded as a direct result of being a member of the United Nations, and,

WHEREAS, the Congress of the United States has ignored for eight years a bill to repeal the United Nations Charter,

NOW, THEREFORE, BE IT RESOLVED, the Indiana State Medical Association requests the legislature of the state of Indiana to repeal the United Nations Charter for this state so that other states will follow their example until three-fourths of our states have done likewise.

Resolution No. 70-8

Introduced by: COMMISSION ON AGING
Subject: INSURANCE COVERAGE FOR HOME HEALTH CARE
Referred to: REFERENCE COMMITTEE #4

WHEREAS, there seems to be an ever-increasing awareness of the need of high-quality medical care for the aged, and,

WHEREAS, there is no simple answer since the medical needs of the aged are

multiple, complex and variable from time to time, and,

WHEREAS, the Commission on Aging and the Indiana State Medical Association are fully and completely aware of the increasing, and almost overwhelming cost of these projects of care for the aging,

NOW, THEREFORE, BE IT RESOLVED, that those third parties, such as Blue Cross, independent insurance companies and government agencies, but not exclusively these, seriously look into the feasibility of the use of prepaid or insurance coverage to provide payment for paramedical personnel, to be specially trained to look after the elderly people, who may be able to be maintained in their own homes. It is our sincere opinion that this would be done at a lesser cost than keeping a person in a nursing home, and much less cost than keeping a person in a continued-care home, and tremendously less costly than hospitalization, and that by this provision, the family doctors might thereby be encouraged to treat as many of these people in their offices and homes as feasible.

Resolution No. 70-9

Introduced by: COMMISSION ON AGING
Subject: DEVELOPMENT OF PARTIAL DISABILITY CATEGORY
Referred to: REFERENCE COMMITTEE #4

WHEREAS, the Indiana State Medical Association is unalterably adherent to the policy that the doctors of Indiana, as members of the Indiana State Medical Association, give the very highest quality of medical treatment available, and,

WHEREAS, there seems to be considerable inequity in the regulations of the Social Security Disability provisions, namely that a person is either well and able to work fully, or totally and possibly, permanently disabled, prior to being able to be considered for compensation, and,

WHEREAS, there are many people who are able to do some work or who have, because of the nature of their work, reached an age where that type of work is no longer possible, but their inability to carry out their usual occupation is not due to specific physical or emotional disability, but is merely the result of age, and,

WHEREAS, we are convinced that a person's self-esteem is dependent on his ability to be independent and self sustaining,

NOW, THEREFORE, BE IT RESOLVED, that the principle of "partial inability" to carry out their usual occupation, whether it be due to age, disability of a physical, or emotional nature; be considered as an alternative to be adjudged to being totally disabled and unable to do work. This policy would also provide for a period where the person could work, within limits of his ability, and would have opportunities for rehabilitation that are not encouraged by the total disability concept. It is our opinion that this would be economical in that it would encourage rehabilitation.

Resolution No. 70-10

Introduced by: FUTURE PLANNING COMMITTEE
Subject: MEDICAL LIABILITY LIMITS
Referred to: REFERENCE COMMITTEE #4

RESOLVED, that the Committee on Future Planning recommends to the Indiana State Medical Association House of Delegates that legislation be prepared for presentation to the Indiana General Assembly by interested members of that Assembly to combat on a legal basis the ever-increasing problems of medical liability.

One specific recommendation is that legislation be prepared for use of medico-legal panels for pre-trial investigation, or compulsory arbitration. Another should be designed to correct the abuses associated with the contingency fee concept.

Resolution No. 70-11

Introduced by: FUTURE PLANNING COMMITTEE
Subject: METHOD OF ELECTION OF CERTAIN OFFICERS
Referred to: REFERENCE COMMITTEE #5

RESOLVED, that the Committee on Future Planning recommends to the Indiana State Medical Association House of Delegates that the Constitution be amended to include the following ways of getting new, wider and more active participation of the membership:

(a) ISMA trustees and AMA delegates and members of the ISMA House of Delegates be elected by a vote of the entire membership which they represent,

(b) All elections should be by mail ballot,

(c) At least two candidates, for every trustee and delegate office, be submitted by the nominating committee,

(d) To win a candidate must have a 30% plurality of the entire membership —not just a majority of the votes cast. If the candidate receives less than the required 30%, the election would be invalid and a new election would be held.

Resolution No. 70-12

Introduced by: FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY
Subject: SUPPORT OF INDIANA PLAN MEDICAL EDUCATION
Referred to: REFERENCE COMMITTEE #3

WHEREAS, the Indiana University School of Medicine for the past two bienniums has developed and operated its new statewide program of medical education made possible by Senate Enrolled Act No. 359, and,

WHEREAS, the original objective of increasing the number of graduate and continuing medical education programs is being met, and,

WHEREAS, the further objective of increasing the retention of Indiana University graduate physicians, as well as drawing physicians from out of state by the aforementioned objective, and,

WHEREAS, continued funding of this program is necessary for continued and increasing fulfillment of its objectives,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association commend the Indiana University School of Medicine on its far-sighted program, which has been successful, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Associaion House of Delegates recommend to the State Legislature at its next session to continue to fund Senate Enrolled Act No. 359.

Resolution No. 70-13

Introduced by: TWELFTH DISTRICT MEDICAL ASSOCIATION
Subject: PHYSICAL EXAMINATIONS FOR SCHOOL EMPLOYEES
Referred to: REFERENCE COMMITTEE #3

WHEREAS, the present Indiana law concerning teachers' examinations and tuberculosis testing of school personnel is vague and subject to varying interpretations at the local county and school district levels, and,

WHEREAS, definite language in the law as to the type of tests, extent of examination, etc., is desirable and needed for purposes of uniformity of cost accounting, delivery of service, etc.,

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates, in duly constituted assembly, endeavor to modify the existing law of the statute books of the state of Indiana so as to definitely ascertain the type of tuberculosis test, ex-

tent of examinations of school personnel, frequency of examinations, etc., and,

BE IT FURTHER RESOLVED, that this be achieved through the proper commissions and/or committees of the Indiana State Medical Asscciation so that the context of this resolution can be conveyed to the next state legislative session of the Indiana State Legislature.

Resolution No. 70-14

Introduced by: FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY
Subject: SUPPORT OF GOVERNOR'S COMMISSION ON MEDICAL EDUCATION PLAN
Referred to: REFERENCE COMMITTEE #3

WHEREAS, the Governor's Commission on Medical Education has made specific recommendations in its report which will enable the Indiana University School of Medicine, through the mechanism of a statewide network of universities and community hospitals, to provide undergraduate medical education, enabling the immediate increase in the number of medical students trained by the Indiana University School of Medicine, and,

WHEREAS, the recommendations would, by 1973, enable the Indiana University School of Medicine to increase its class enrollment by 100 students, and,

WHEREAS, these recommendations would enable the Indiana University School of Medicine to immediately increase the production of physicians in the state of Indiana which, together with prior legislation improving the distribution of physicians in Indiana, would help to relieve Indiana's physician shortage,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association commend the Governor's Commission on an excellent report, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association commend the Indiana University School of Medicine and its consultants, working with the Governor's Commission on Medical Education in helping to prepare an excellent workable program as outlined in the report, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association recommend to the State Legislature at its next session, that the Governor's Commission report and its recommendation be accepted and that legislation be enacted to enable funding and implementation of these recommendations.

Resolution No. 70-15

Introduced by: FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY
Subject: SEMI-ANNUAL MEETINGS—HOUSE OF DELEGATES
Referred to: REFERENCE COMMITTEE #5

WHEREAS, the activity of the Indiana State Medical Association has become so momentous that a single session of the House of Delegates is not sufficient to conduct and perform all of the duties of the association,

NOW, THEREFORE, BE IT RESOLVED, that a yearly spring business session be established and mandated to aid in the conduct of the business and affairs of the association.

Resolution No. 70-16

Introduced by: LaPORTE COUNTY MEDICAL SOCIETY
Subject: MEDICAL DEPARTMENT—BOARD OF CORRECTIONS
Referred to: REFERENCE COMMITTEE #4

WHEREAS, many members of the LaPorte County Medical Society have either worked in the Michigan City Prison medical department or have served as consultants and are aware of the medical needs of the inmates of the Michigan City Prison, and,

WHEREAS, the LaPorte County Medical Society has annually for the past eight years recommended to the state government through the state medical association the idea of organizing the medical care in the Department of Corrections in a more efffficient manner, and,

WHEREAS, a survey of the medical needs of our state prisons by the U. S. Public Health Department in 1968 confirmed this recommendation, and,

WHEREAS, on July 19, 1970, Governor Edgar Whitcomb publicly stated that he has established a commission whose purpose is to improve conditions and programs in our state correctional institutions, and,

WHEREAS, the Indiana State Board of Corrections is responsible for the total medical care of all inmates under their supervision,

NOW, THEREFORE, BE IT RESOLVED, that the LaPorte County Medical Society urges the Indiana State Medical Association to again recommend to the state government the establishment of a medical department within the Board of Corrections.

Resolution No. 70-17

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY
Subject: REPORTING DISPOSITION OF PREVIOUS HOUSE ACTIONS
Referred to: REFERENCE COMMITTEE #5

WHEREAS, much attention, ingenuity, inspiration and concern are invested in the reports, resolutions and speeches presented to each annual meeting of this House of Delegates, and,

WHEREAS, these matters are then carefully and thoughtfully discussed before Reference Committees, and recommendations are then formulated by the committee, and,

WHEREAS, the House of Delegates further considers each proposition before adopting a decision, and,

WHEREAS, certain recommendations are then given to the Board of Trustees or to a commission, or to a specific officer for further action,

NOW, THEREFORE, BE IT RESOLVED, that at the next succeeding meeting of the House of Delegates, each matter so delegated be reported back to the House with respect to its disposition or status, and,

BE IT FURTHER RESOLVED, that the Executive Secretary be given the responsibility of presenting this information to the House.

Resolution No. 70-18

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY
Subject: REPORTING OF AMA DELEGATION POSITIONS ON ISSUES
Referred to: REFERENCE COMMITTEE #5

WHEREAS, the policies and the functioning of the AMA have significant impact and continuing effects upon practicing physicians, and,

WHEREAS, the decisions made by the AMA House of Delegates on matters such as the dues structure, ethical standards (e.g., abortion), educational requirements (e.g., phasing out internships), and relationships with third parties (such as governmental), are of vital concern to AMA members, and,

WHEREAS, the delegates to the AMA are entrusted with the responsibility of properly and effectively representing all the members of ISMA,

NOW, THEREFORE, BE IT RESOLVED, that the delegation to the AMA

from ISMA be required to report to the Board of Trustees and to the House of Delegates how each delegate voted on every matter of substantial significance or involving controversy, and also any formal positions taken as a delegation, or as individual delegates, in election contests at each AMA meeting, and,

BE IT FURTHER RESOLVED, that such reports be made to the House of Delegates no later than its first meeting, at the annual convention.

Resolution No. 70-19

Introduced by: LaPORTE COUNTY MEDICAL SOCIETY
Subject: HOOSIER TEEN HAPPENING
Referred to: REFERENCE COMMITTEE #4

WHEREAS, members of the LaPorte County Medical Society were both impressed and proud of the action of the Indiana State Medical Association in organizing the program "Teen Health Happening," and,

WHEREAS, response to this program on the part of the teenagers was definitely favorable, the LaPorte County Medical Society wishes first to commend the present officers for their action in organizing the program, and strongly recommends to the incoming officers that the program be continued unless it is not economically feasible.

Resolution No. 70-20

Introduced by: LAKE COUNTY MEDICAL SOCIETY
Subject: LICENSING OF MEDICAL ASSISTANTS
Referred to: REFERENCE COMMITTEE #4

WHEREAS, legislation leading to the licensing of medical assistants has been suggested by various organizations, and,

WHEREAS, a number of hazards exist of equal importance compared to the advantages of such legislation,

NOW, THEREFORE, BE IT RESOLVED, that a thorough study of this matter be conducted by an appropriate commission of the Indiana State Medical Association before any sponsorship or support of such legislation be conducted by the association.

Resolution No. 70-21

Introduced by: MARION COUNTY MEDICAL SOCIETY
Subject: INEQUITIES IN DUES PAYMENTS
Referred to: REFERENCE COMMITTEE #5

WHEREAS, the Marion County Medical Society and, perhaps, other county medical societies in Indiana, require applicants for membership, who are not elected to membership until after July 1 of any one year, to pay only one-half the amount of the annual dues, and,

WHEREAS, the Marion County Med'cal Society and, perhaps, other county medical societies in Indiana, do not require interns and residents to pay dues, and,

WHEREAS, the American Medical Association has the same policies, and,

WHEREAS, the Indiana State Medical Association grants a reduction in dues only to those physicians elected to their first membership after October 1 of any one year, and,

WHEREAS, the Indiana State Medical Association requires interns and residents to pay annual dues of $15.00,

NOW, THEREFORE, BE IT RESOLVED, that Chapter XXX.—County Societies, Sec. 12, of the Constitution and Bylaws of the Indiana State Medical Association be amended to provide that physicians who are elected to their first membership after July 1 of any one year be required to pay only one-half the amount of the annual dues and to provide further that no dues payments be required of interns and residents.

Resolution No. 70-22

Introduced by: FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY
Subject: ABORTION POLL
Referred to: REFERENCE COMMITTEE #5

WHEREAS, the American Medical Association in its 119th Annual Convention, through the action of the House of Delegates, adopted a positive, permissive policy on abortion, in effect asking that such an operation be legalized, and,

WHEREAS, there was much controversy concerning such a resolution before its passage, and has been much more since that time, and,

WHEREAS, it is not at all certain whether such action represents the will of the majority of the members of the AMA,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association petition the American Medical Association to reconsider the action of the House of Delegates of the 119th Convention concerning abortion, and,

BE IT RESOLVED, that the Indiana State Medical Association poll its membership to determine the percentage favoring and not favoring the aforementioned resolution, such results to be forwarded to the AMA for their study and consideration.

Resolution No. 70-23

Introduced by: FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY
Subject: FINANCING OF RENAL FAILURE
Referred to: REFERENCE COMMITTEE #4

WHEREAS, advances in medical technology in the past decade make it possible for patients with "terminal" renal failure to live and be restored to a relatively normal and productive life, and,

WHEREAS, the great majority of citizens of Indiana suffering from chronic renal disease are denied such therapy because existing sources and methods of financial support are grossly insufficient,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association recommends and urges the passage of a bill by the Indiana State Legislature to provide necessary financial support.

Scientific Exhibits

S. O. WAIFE, M.D., *Indianapolis, Chairman*

SIDE EFFECTS OF PHENOTHIAZINES

Exhibitor: Douglas Goldman, M.D., Cincinnati, Ohio
Attendant: Douglas Goldman, M.D.

The advent of phenothiazines has been an important advance in the management of mental illness.

Recognition and control of the side effects of these agents is essential for optimal therapy.

MEDICINE AND RELIGION

Exhibitor: Indiana State Medical Association Committee on Medicine and Religion—AMA Department of Medicine and Religion
Attendant: Burton Kintner, M.D., chairman of Medicine and Religion Committee

This exhibit is to publicize the work of the state Committee on Medicine and Religion. Through the members of the committee, who staff the exhibit, names and addresses of interested persons throughout the state will be obtained.

Information about the program will be disseminated to the membership of the state medical association about the program on medicine and religion.

CUTANEOUS COMPLICATIONS OF IMMUNOSUPPRESSIVE THERAPY

Exhibitor: Wilma F. Bergfeld, M.D., Cleveland, Ohio
Co-Exhibitors: James G. Ryan, M.D., F.R.C.P. (C)
Henry H. Roenigk, Jr., M.D.
S. Nakamoto, M.D.
S. D. Deodhar, Ph.D., M.D.
R. R. Evans, M.D.
Attendant: Wilma F. Bergfeld, M.D.

This exhibit reviews the cutaneous complications of immunosuppressive therapy in the treatment of 215 renal transplant patients. The immunosuppressive agents were Prednisone, Imuran, Antilymphocytic globulin and Antinomycin C.

The vast majority of the cutaneous lesions can be classified as infectious disorders of bacterial, fungal and viral etiology. The remaining are represented by neoplasms, hypersensitivity reactions, blood and vascular and miscellaneous disorders. In addition to the exhibit is a clinical evaluation of the complications in Methotrexate therapy in 204 severe psoriasis patients who were treated with Methotrexate 24 mg. orally at weekly intervals.

COMPLICATIONS OF HAIR TRANSPLANTATION

Exhibitor: D. Bluford Stough, III, M.D., Hot Springs, Ark.
Attendant: D. Bluford Stough, III, M.D.

Syncope, bleeding, edema, infection, scarring, poor hair growth, arteriovenous fistulas, foreign body reactions and Alopecia Areata are some of the problems encountered in hair transplantation for the alleviation of permanent forms of alopecia.

This exhibit, through the display of color transparent photos, shows the methods of coping, correcting and preventing complications which may arise in this type surgery, due to the continued refinement of the punch autograft procedure, through adequate knowledge and experience.

Recognition of these preventative and corrective measures has been a source of encouragement to those who were hesitant about undergoing hair transplantation to correct male pattern baldness, and traumatic and surgical scars.

TOTAL PROSTHETIC REPLACEMENT OF THE HIP JOINT

Exhibitor: Merrill A. Ritter, M.D., Indianapolis
Attendant: Merrill A. Ritter, M.D.

Recent advancement in the field of hip surgery has enabled us to implant a more adequate joint replacement. Results following hemi-joint and mild arthroplasty have, at best, been no better than 70% satisfactory and here one needs to be on crutches and exercises for an indefinite period of time.

Now with total replacement of the hip joint and fixation with an acrylic cement, one can offer better than a 95% satisfactory result and crutches and exercises are not a necessity.

DOSE RESPONSE: KEY TO EFFECTIVE TREATMENT

Exhibitor: Fred J. Phillips, M.D., Quakertown, Pa.
Attendant: Fred J. Phillips, M. D.

A large segment of patients with arthritis, musculoskeletal and inflammatory problems seen in today's general practice respond with more predictable results when effective therapy is coupled with a careful dosage program.

A comprehensive management program and the results of our experience with 281 patients over a period of three years, employing short as well as long term therapy, is presented.

The schedule employed to effect a dose reduction to the smallest maintenance level, thus affording an economic advantage to the patient, is outlined.

CHEMOSURGERY FOR RECURRENT AND INVASIVE CANCER OF THE SKIN

Exhibitor: Barry A. Goldsmith, M.D., Chicago, Ill.
Co-Exhibitor: Milton W. Eisenstein, M.D., Chicago, Ill.

Carcinoma of the skin is readily apparent, easily accessible and susceptible to treatment. However, two thousand cases per year in the United States die of skin cancer, and many others suffer discomfort, pain and deformity, with worsening, apparently incurable, lesions. The problem is that recurrent cancer of the skin, and a few other well-defined categories of skin cancers, are difficult to treat successfully with conventional therapy (i.e., surgery or radiation).

Chemosurgery is a newer form of surgical treatment, based on systematic surgical excision of previously chemically fixed tissue, with microscopic control of the entire specimen removed. It has been shown to be highly effective in dealing with these problem cases with conservation of remaining tissue and safety to the patient. Confirmative statistical data is presented.

The exhibit will describe chemosurgery and explain its indications.

OPERATION TO REVASCULARIZE THE HEART—LONG-TERM RESULTS

Exhibitor: David S. Leighninger, M.D., Chicago, Ill.
Co-Exhibitors: M. S. Mazel, M.D., R. Riera, M.D., E. Manolopoulos, M.D., I. Callen, M.D., Chicago, Ill.
Attendants: David S. Leighninger, M.D.
Mrs. David S. Leighninger, Technician

Does the Beck-Leighninger operation to revascularize the heart help the coronary patient? This is an especially pertinent question today. It can be answered on the basis of longevity and the quality of life in a large group of patients followed over a long period of time. These parameters for patients operated upon or not operated upon are presented.

Average yearly survival figures indicate a significantly improved outlook for patients operated upon. That good clinical results are obtained and that the results hold up with the passage of time are indicated by observing the quality of life in the operated patients.

IAGP ORGANIZATIONAL EXHIBIT

Exhibitor: Indiana Academy of General Practice, Indianapolis
Attendants: Mrs. Jackie Schilling
Jerome E. Holman, Jr., M.D.
Alvin J. Haley, M.D.

The Indiana Academy of General Practice membership and organizational exhibit pictures the functions of the Academy relative to the governing body, committee structure and activities.

Membership material will be available for distribution. One prerequisite for membership in the Academy is membership in the Indiana State Medical Association and local medical society.

HEALTH MANPOWER RECRUITMENT

Exhibitor: Indiana Health Careers, Inc., Indianapolis
Attendants: Jan Davidson
Dennis Dawes
Charles Tootle

Indiana Health Careers is a non-profit service organization which conducts a coordinated health manpower recruitment program for the state of Indiana. This program is supported by voluntary contributions from eighty-one (81) member organizations. These member organizations include professional associations, official and voluntary health agencies, the Indiana Hospital Association, educational institutions, and, to a limited extent, corporations.

The major emphasis of the program provides information to guidance counselors and students at the junior high, senior high, and college levels, aimed at enticing them into the more than 200 health careers. This is accomplished through a clearinghouse of informational materials; the services and direction of staff consultants who are qualified to work in the classroom; the development and service of health careers clubs; a general statewide public relations campaign using all media, and through other appropriate resources. The organization is directed by a board of thirty (30) members with the assistance of a professional advisory council which is composed of a delegate from each of the member organizations.

The basic problem is success! The program has been accepted with enthusiasm to the extent that requests for services far exceed current ability to meet them because of financial limitations.

DANGER! STROKE AHEAD

Exhibitor: Indiana Heart Association, Indianapolis
Attendant: Mr. B. Pat O'Rourke

This display of four panels emphasizes transient symptoms, general evaluation, and predisposing conditions and management.

HEART DISEASE—WHAT DO WE KNOW?

Exhibitor: Dairy Councils of Indiana, Indianapolis
Co-Exhibitors: Mrs. Nancy Rainey, Indianapolis
Mrs. Hazel Burnett, South Bend
Mrs. Carole Diehm, Evansville
Attendant: Mrs. Hazel Burnett

This exhibit will highlight the new Dairy Council booklet "Heart Disease, What Do We Know About Diet as a Risk Factor?" The booklet stresses that, although diet is one of the risk factors under close study, *radical* changes in diet are not recommended on the basis of *present* evidence. Rather, a balanced moderate diet is advocated.

Also displayed will be both professional and patient references for the physician's use in counseling patients about good eating habits.

VEIN GRAFT SURGERY FOR CORONARY ARTERY DISEASE

Exhibitor: Drs. Harry Siderys, John N. Pittman and Gilbert T. Herod, Indianapolis
Attendant: Harry Siderys, M.D.

More than 100 patients have been operated on at Methodist Hospital, Indianapolis, for coronary artery disease. The operation used is the interpolation of a segment of saphenous vein from the aortic root to a point on the coronary artery beyond the obstruction. The operation has been done with less than 10% mortality and marked relief of symptoms in most cases.

HEMOPHILIA

Exhibitor: Indiana Chapter, National Hemophilia Foundation
Attendant: Mrs. Ralph B. Milburn

Exhibit will consist of a three panel poster display outlining information about hemophilia. There also will be medical literature available for the physicians.

OCCULT FRACTURES

Exhibitor: Indiana Bone & Joint Club
Attendants: Members of the Indiana Bone and Joint Club

Some fractures are difficult to determine at the time of the initial x-ray study. Some of these problems will be demonstrated and discussed.

THE CLINICAL LABORATORY IN THE IDENTIFICATION AND MANAGEMENT OF THE HIGH RISK PREGNANCY PATIENT

Exhibitor: Hudson Medical Group, Inc., Elkhart
Co-Exhibitors: Edward P. Mininger, M.D.
George Thompson, M.S.
Henry Wishinsky, Ph.D.

The amount of estriol excreted in the 24-hour urine specimen of a pregnant woman is now an accepted index to the condition of the fetus. When toxic conditions threaten the life of the growing fetus, the estriol excretion decreases in amount.

This exhibit summarizes some of the biochemistry and the physiology in estriol metabolisms. Estriol excretion is used as an index to fetal welfare. The normal and abnormal levels are recorded in the exhibit. The practical uses of estriol studies in a hospital clinical laboratory for the office and hospital practice of obstetrics are the points of emphasis of this exhibit.

MODERN TEACHING METHODS IN OBSTETRICS AND GYNECOLOGY

Exhibitor: Department of Obstetrics and Gynecology, Indiana University Medical Center, Indianapolis
Co-Exhibitors: Charles A. Hunter, M.D.
Wayne L. Johnson, M.D.
James Carter, M.D.

This exhibit will demonstrate the newer educational approaches in use in the Department of Obstetrics and Gynecology at Indiana University School of Medicine. The exhibit will consist of audio-visual materials and models.

RECOGNITION & TREATMENT OF FATTY EMBOLISM, A COMMON POST-TRAUMATIC CLINICAL DISEASE!

Exhibitor: John E. Krueger, M.D., South Bend
Co-Exhibitor: James Serwatka, M.D., St. Joseph's Hospital, South Bend
Attendant: James Serwatka, M.D.

Fatty embolism is a very common clinical complication of postoperative and post-traumatic patients, affecting primarily lungs and brain.

It has previously been undiagnosed in many cases.

It is extremely serious in its more advanced stages, but mortality and morbidity rates can be drastically reduced when the following conditions and regime are followed:

1. Early diagnosis.
2. Early and adequate pulmonary care, often including tracheostomy, and continuous positive pressure ventilation.
3. Heparinization.
4. Antibiotic therapy.
5. Maintenance of fluid and electrolyte balance.

The blood gases must be monitored. Excessive hyperthermia should be controlled by cooling. Tachypnea must be controlled by sedation. Severe pulmonary congestion can lead to right heart failure.

Do not discontinue intensive therapy too soon!

PREVENTION OF BLINDNESS IN PREMATURE INFANTS

Exhibitor: Indiana Society for the Prevention of Blindness
Attendants: Mrs. Dorothy Maxwell
Mrs. Carolyn Hippensteel

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS, STATE OF INDIANA

Exhibitor: Amercian Association of Medical Assistants, State of Indiana
Attendants: Ella Mae Mow
Beatrice Judah

Exhibit booth will contain information pamphlets regarding our organization, publications on the national, state and local levels and poster of the Medical Assistants Code of Ethics. Medical assistants will be in attendance at booth to answer questions regarding the medical assistants organization.

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

Exhibitor: Indiana Chapter, AAPS
Attendant: Arthur Seeds or assistant

The exhibit, sponsored by the Association of American Physicians and Surgeons, will aid in promotion of the advantages and benefits of membership in the organization.

The overall goal is to improve medical care of individuals within a free choice, private, competitive market economy.

Individuals who view the exhibit thoughtfully and carefully will receive the message that American doctors are the best in the world and so is the American medical system; that the quality and quantity of American medical care has never been excelled in the history of mankind; that ethical physicians do not need to compromise with unethical politicians and bureaucrats, and that only doctors can practice good medicine.

The many services and activities of the association will be presented to the viewing audience, including news letters and bulletins, legislative services, research and fact-finding projects, literature for physicians and the public, education of physicians in training, and regular AAPS services such as information central, library services, speaker services, and major national meeting events.

Technical Exhibitors—1970

AMERICAN MEDICAL FACILITIES CORPORATION **Booth 19**
Box 655 St. Louis, Mo.
Lee J. Marchant, Jeanette C. Pierce, Barry Marchant

ARNAR-STONE LABORATORIES, INC. **Booth 55**
601 E. Kensington Rd. Mt. Prospect, Ill.
David Sprehe, Jerry Myers, Bill Snider

ASTRA PARMACEUTICAL PRODUCTS, INC. **Booth 11**
7 Neponset St. Worcester, Mass.
Thomas McCarthy

AUTOMATED MANAGEMENT SYSTEMS, INC. **Booth 22**
5016 Knoll Crest Ct. Indianapolis, Ind.
C. J. Ohlson, C. E. Kile

AYERST LABORATORIES **Booth 50**
685 Third Ave. New York, N.Y.

BEST BUSINESS PRODUCTS **Booth 71**
5410 S. Meridian St. Indianapolis, Ind.
C. F. Cole, Keith Sidebottom

BLUE SHIELD OF INDIANA **Booth 21**
110 N. Illinois St. Indianapolis, Ind.
H. P. Dixon, G. R. Miller, J. D. Martin, F. D. Harbridge, T. E. Erwin

BRISTOL LABORATORIES **Booth 12**
P. O. Box 657 Syracuse, N.Y.
Roger Massa, William J. O'Neil, John R. Welten, Joseph R. Zickgraf, James R. Riddle

BURROUGHS WELLCOME & CO. (U.S.A.) INC. **Booth 1**
One Scarsdale Rd. Tuckahoe, N. Y.

CIBA PHARMACEUTICAL COMPANY **Booth 30**
556 Morris Ave. Summit, N. J.
Marshall J. Kitterman, William Miller

CLAYTON L. SCROGGINS ASSOCIATES **Booth 10**
200 Northland Blvd. Cincinnati, Ohio
Clayton L. Scroggins, Lee W. Scroggins and David C. Scroggins

COCA-COLA COMPANY **Booth 46**
P. O. Drawer 1734 Atlanta, Ga.

ELI LILLY AND COMPANY **Booth 45**
P. O. Box 618 Indianapolis, Ind.
J. E. Haynes, F. W. McAllister, D. W. Haney, D. R. Hollingsworth

EQUITY FUNDING CORPORATION OF AMERICA **Booth 74**
3101 E. 38th St. Indianapolis, Ind.

FINANCIAL MANAGEMENT INSTITUTE **Booth 67**
136 Ludlow St., #500 Dayton, Ohio
Glen Gerber, Dick Dellinger

GEIGY PHARMACEUTICALS **Booth 7**
444 Saw Mill River Rd. Ardsley, N.Y.

MEAD JOHNSON LABORATORIES **Booth 25**
2404 Pennsylvania Ave. Evansville, Ind.
Ed Corns, William Kieffer

MEDCO PRODUCTS **Booth 14**
2817 Parklawn Dr. Dayton, Ohio
Jess Fink

MERCK SHARP & DOHME **Booth 15**
West Point, Pa.
John P. Thamart, Archiel F. Dunn, John C. Pease, Chris A. Brooks

MERRILL LYNCH, PIERCE, FENNER & SMITH, INC. **Booth 23**
110 W. Berry St. Fort Wayne, Ind.
Lawrence W. Roberts

ORTHO PHARMACEUTICAL CORPORATION **Booth 2**
Raritan, N.J.
Dan Telfer, Al Legal, Mike Donley

PARKE, DAVIS & COMPANY **Booth 35**
GPO Box 118 Detroit, Mich.

PFIZER LABORATORIES **Booth 66**
235 E. 42nd St. New York, N.Y.

PITNEY-BOWES INC. **Booth 24**
1539 N. Ironwood South Bend, Ind.
David Hand, A. T. Reed, Richard McIntyre, Paul Boyer, J. E. Carrico, Nicholas Rees

PROFESSIONAL CORPORATION SERVICE ASSOC. **Booths 4 and 5**
2205 Commonwealth Bldg. Louisville, Ky.
Charles Hansen

PROFESSIONAL MANAGEMENT **Booth 17**
3221 Crescent Ave. Fort Wayne, Ind.
Paul Evans, George R. White, Richard Lusk, Harold L. Neff, L. Thomas Booth, Tommy L. Greggand, Berton H. Bryan

A. H. ROBINS COMPANY **Booth 6**
1407 Cummings Drive Richmond, Va.
Victor Grayson

J. B. ROERIG DIVISION **Booth 65**
235 E. 42nd St. New York, N.Y.

WILLIAM H. RORER, INC. **Booth 69**
500 Virginia Dr. Fort Washington, Pa.
Joseph F. Cashen

SANDOZ PHARMACEUTICALS **Booth 56**
Route #10 Hanover, N.J.
Doane Morgenthaler

W. B. SAUNDERS COMPANY **Booth 31**
7th and Locust St. Philadelphia, Pa.
William Ward

SCHERING LABORATORIES **Booth 3**
1011 Morris Ave. Union, N.J.
John Wise, Maurice Hoban

SMITH KLINE & FRENCH LABORATORIES **Booth 40**
1500 Spring Garden St. Philadelphia, Pa.
B. Mooneyham, C. Oswald

ST. JOHN BUSINESS MACHINE COMPANY **Booth 72**
1134 Lincolnway East South Bend, Ind.

E. R. SQUIBB & SONS, INC. **Booth 20**
909 Third Ave. New York, N.Y.

NORM SWANSON ASSOCIATES **Booth 42**
5610 Crawfordsville Rd., #24 Indianapolis, Ind.

THE MEDICAL PROTECTIVE COMPANY **Booth 41**
Fort Wayne, Ind.
Kenneth W. Moeller, Philip P. Capasso

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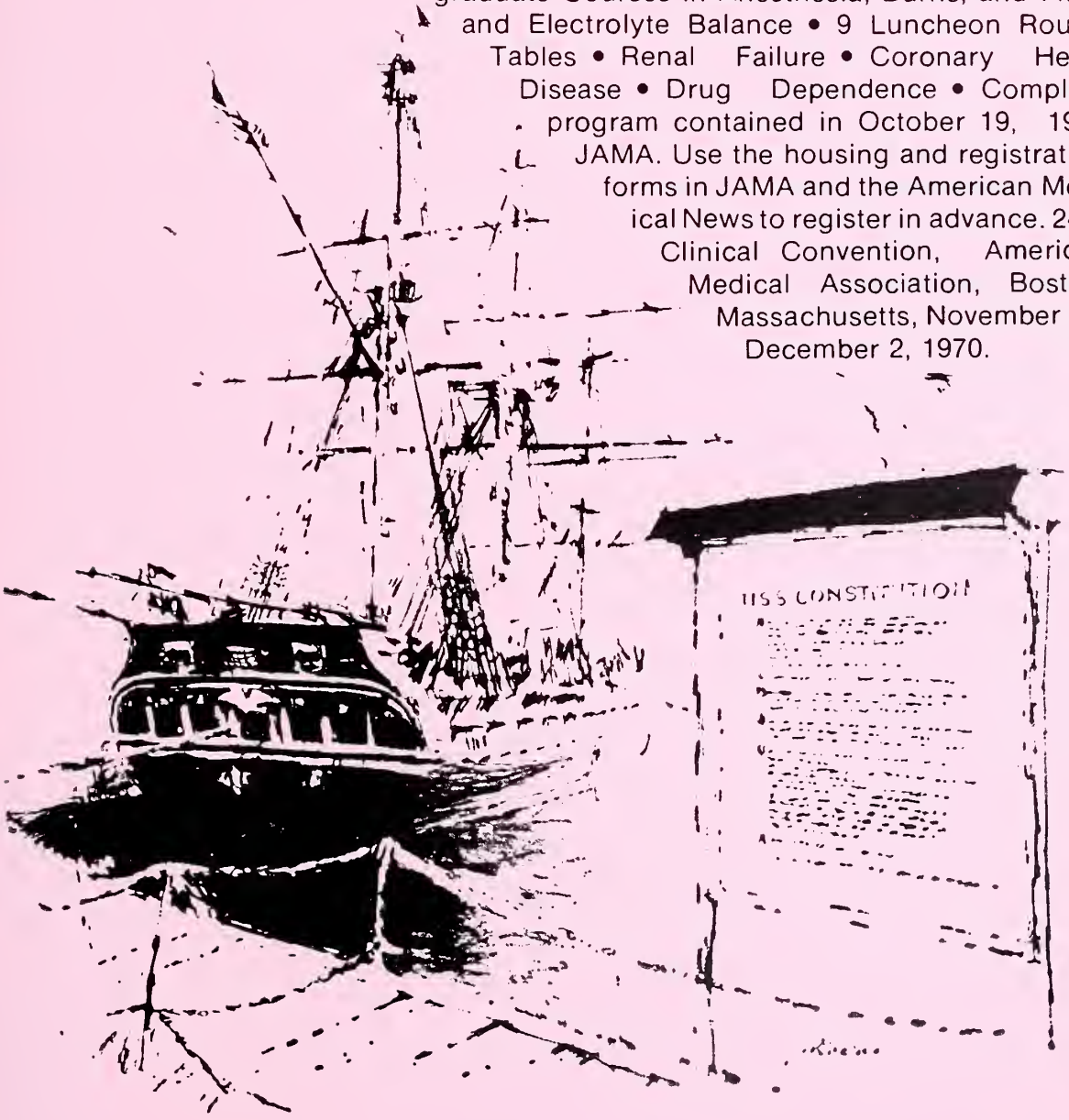
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24th AMA Clinical Convention in Boston, Massachusetts November 29-December 2, 1970

WHAT'S NEW IN MEDICINE? Numerous scientific sessions at the AMA 24th Clinical Convention will provide the answers • Clinical Immunology • Clinical Gynecology • Pollution and the Physician • 3 Postgraduate Courses in Anesthesia, Burns, and Fluid and Electrolyte Balance • 9 Luncheon Round Tables • Renal Failure • Coronary Heart Disease • Drug Dependence • Complete program contained in October 19, 1970 JAMA. Use the housing and registration forms in JAMA and the American Medical News to register in advance. 24th Clinical Convention, American Medical Association, Boston, Massachusetts, November 29-December 2, 1970.



Art, Hobby Show Planned For ISMA South Bend Meeting

Space will be provided at the 1970 annual meeting of the Indiana State Medical Association, October 13, 14 and 15, at South Bend for a Physicians' Art and Hobby Show.

The Woman's Auxiliary of the Indiana State Medical Association has been invited to participate in the show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Mrs. Dan Stiver, Chairman
1127 East Wayne St., N.
South Bend, Indiana 46615

Mrs. Eldred MacDonell
1757 Juday Lake Drive
South Bend, Indiana 46635

Mrs. Lester Borough
816 Woodside Avenue
South Bend, Indiana 46614

It will be the responsibility of each physician to see that his work gets to the exhibition at the Athletic and Convocation Center, Notre Dame University, South Bend. Final arrangements will be taken care of by the committee.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

We solicit your exhibit to make this the largest and best ever this year.

Application for Space in Art and Hobby Show Exhibit

Mail to:
Mrs. Dan Stiver
1127 E. Wayne St., N.
South Bend, Ind. 46615

Name_____

Address_____

City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

Other information_____

_____

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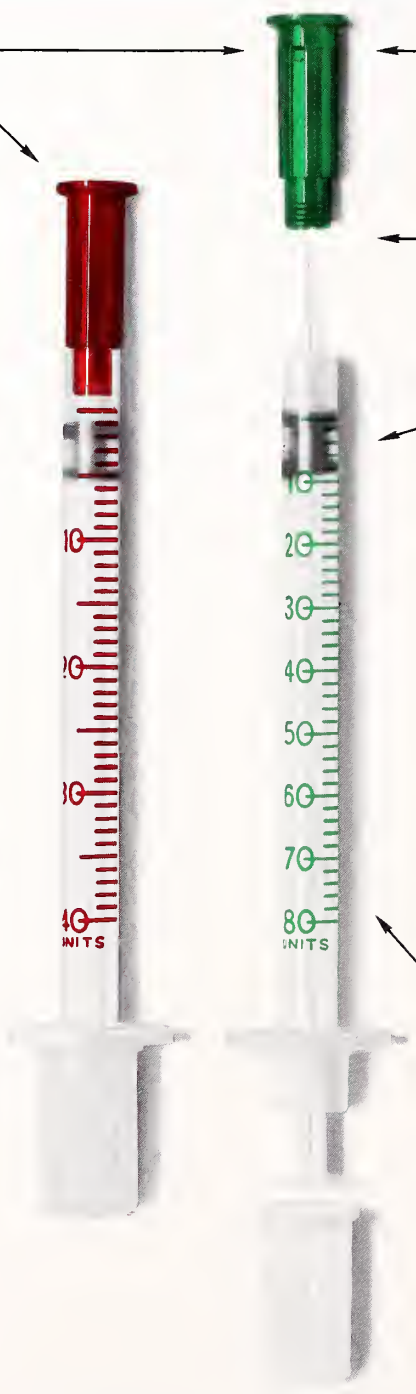
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The Indiana Program—A Progress Report

DEAN GLENN W. IRWIN, JR.
STEVEN C. BEERING, M.D.
GEORGE T. LUKEMEYER, M.D.
*Indianapolis**

THE Indiana Program for Statewide Medical Education began in 1967 when the General Assembly of the State of Indiana authorized funds for strengthening internships, residencies, and continuing medical education programs in community hospitals throughout the state. Indiana became the first and only state to date to have provided funds for this purpose. Over the past three and a half years, $5,500,000 have been distributed for the support of salaries of community directors of medical education, stipend supplements for interns and residents, the creation and maintenance of a sophisticated medical telecommunication system, a program of visiting professorships and joint clinics and a large number of individual grants-in-aid for community hospital education programs.

One of the main purposes of enacting this legislation was to stem the "midwest brain-drain" of qualified physicians by retaining and attracting more doctors to the state of Indiana. These hopes have clearly been realized as there are now 537 interns and residents pursuing their training in the hospitals of Indiana. This figure represents an increase of 103 physicians over the number serving their training three years ago.

In 1968 the Indiana University School of Medicine, in collaboration with Purdue and Notre Dame Universities, embarked upon pilot programs for the teaching of basic medical sciences. Over the past two years ten students have been admitted to the pilot programs jointly sponsored by the medical school and the respective graduate schools at Purdue and Notre Dame. This experiment verified the hope that biochemistry, physiology, and microbiology could be successfully taught in an outstanding university away from the Indiana University Medical School. After taking anatomy in a special summer session, most of these students joined their classmates in the regular sophomore curriculum.

Despite the fact that over the past 15 years, Indiana University School of Medicine had increased its entering class size from 150 to 227 students, we were still going to be critically short of the number of physicians needed in Indiana.

It was against this background, then, that Governor Whitcomb in June of 1969 created a special Commission on Medical Education. This commission was composed of 32 members, approximately one-third of whom are physicians, with the majority representing the lay consumers of medical services, legislators, educators, administrators, businessmen and members of the faculty, administration and student body of the Indiana University School of Medicine. The commission carefully reviewed the previous proposals for remedying the physician shortage in the state of Indiana. Because a new traditional four year medical school would require a lead time of 10 to 12 years to become productive and an investment of approximately $150,000,000, the commission recommended that the existing facilities, faculties and staffs of the state universities, colleges and hospitals be forged into a statewide medical education system. The commission recommended that seven new centers for medical education be created at Evansville, Fort Wayne, Lafayette, Lake County, Muncie, South Bend, and Terre Haute.

On the 11th of February, 1970, the commission resolved to invest the administration of the Indiana University School of Medicine with the responsibility and authority for planning and implementing the new statewide program.

This is the planning year for the new program. In concert with the representatives of the seven communities, we have been actively recruiting outstanding men for the position of center director. At this time, we have identified final candidates for the directorships of four of the proposed new centers. Our basic science faculty have been meeting with their counterparts in the institutions of higher learning of the seven center cities and are defining curriculum needs. Our administrative staffs are projecting budget requirements for the next biennium.

Building on our 12 year experience with the Bloomington Medical Sciences Program, our two year experience with the Pilot Programs at Purdue and Notre Dame Universities and our success with the fourth-year electives in the community hospitals, we are confident that in the fall of 1971, we will be able to enroll approximately 70 new first-year medical students in programs outside Indianapolis. ◄

* From the I.U. School of Medicine, 1100 W. Michigan St., Indianapolis 46202.

HOUSING BUREAU FORM FOR INDIANA MEDICAL ASSOCIATION CONVENTION

Housing Bureau for Indiana Medical Association Convention
Convention & Visitors Bureau
South Bend-Mishawaka Area Chamber of Commerce, Incorporated
320 West Jefferson Boulevard
South Bend, Indiana 46601

Please make hotel/motel reservations as follows:

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Double — $10.00
Twin — $12.00
2 Double (3 persons) — $14.00
2 Double (4 persons) — $16.00

DRAKE MOTEL
Mrs. Jeanette Manzer
60971 U. S. 31 South
South Bend, Indiana
291-3100

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2 Double — $12.00 - $14.00
$2.00 per additional person
$2.00 per crib or cot
4 persons — $16.00

FOUST AIRPORT MOTEL
Lucian Currier
23040 U. S. 20
South Bend, Indiana
233-3131

Single — $12.00 - $14.00
Double — $14.00 - $16.00 - $18.00
2 Double — $18.00
$2.00 per additional person

GARRETT MOTEL
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423 West McKinley Avenue
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259-3731

Single — $9.00
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Mr. & Mrs. Harvey Stallter
50520 U. S. 31 North
South Bend, Indiana
272-7555

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2 people (2 beds) — $11.00
3 people (2 beds) — $12.00

HOLIDAY INN OF SOUTH BEND Lyle Utterback 515 Dixieway North South Bend, Indiana 272-6600	(ALL ROOMS, TWO DOUBLE BEDS) 1 Person — $12.00 2 Persons — $17.00 $2.00 per additional person Children under 12 free when using same facilities as their parents
HOWARD JOHNSON'S Leonard Davis 52939 U. S. 31 North South Bend, Indiana 272-1500	Single — $12.00 - $14.50 Double — $14.50 - $15.50 Twin-Single — $16.50 - $17.50 Twin-Double — $19.50 $3.00 per additional person $3.00 per cot No charge for cribs
KENROSE MOTEL Mr. & Mrs. Casimer Niedbalski 25725 U. S. 20 West South Bend, Indiana 232-3375	Single — $7.50 Double — $9.00 Twin — $12.00 - $14.00 $2.00 for cots
LASALLE HOTEL Michael Papineau 237 North Michigan Street South Bend, Indiana 233-1181	Single — $7.50 - $14.00 Double — $10.50 - $18.00 Twin — $13.00 - $20.00 $3.00 per additional person $3.00 rollaways
MORRIS INN John Rash University of Notre Dame Campus Notre Dame, Indiana 234-0141	Single — $12.00 Double — $17.00 Single Corner Room — $13.00 & $18.00 Double Corner Room — $18.00 & $22.00 Anyone desiring meeting or sleeping room contact the Center for Continuing Education at Notre Dame — Dr. John Reinbold, Asst. Director — 284-7508
MOTOR HAVEN MOTEL Williams Andrews 11729 U. S. 20 Mishawaka, Indiana 255-6111	Single — $7.00 Double — $9.00 2 Double — $12.00 $2.00 per additional person
NIGHT FALL MOTEL Mrs. Ann Harner U. S. 20, McKinley Highway Osceola, Indiana 674-8818	Single — $7.00 Double — $10.00 2 Doubles — $12.00 $2.00 per cot
PANGFORD MOTEL Lawrence Gradeless 14933 U. S. 20 Mishawaka, Indiana 259-5421	Single — $8.00 Double — $10.00 2 Double — 2 persons — $12.00 3 person — $14.00 4 persons — $16.00 $2.00 per additional person
RAMADA INN Armand Lysak 52890 U. S. 31 North South Bend, Indiana 272-5220	Single — $12.00 - $16.00 Double — $15.00 - $18.00 Twin — $16.00 - $19.00 $3.00 per additional person
RANDALL'S INN John Varga 130 Dixieway North South Bend, Indiana 272-7900	Single — $13.00 - $15.00 Double — $16.00 - $18.00 Twin — $18.00 - $20.00 2 Double — $21.00 - $22.00 2 Room Suites — $38.00 $3.00 per additional person $3.00 per cot

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TRAVELODGE OF SOUTH BEND Burt & Lynn Belaire 614 North Michigan Street South Bend, Indiana 233-1154	Single — $10.50 - $13.00 Double — $12.50 - $15.00 Twin — $14.50 - $17.00 $2.00 - $3.00 per additional person

D.C. Medical Society Takes Steps to Discourage Smoking

The Medical Society of the District of Columbia, in mid-January, launched a new offensive against smoking. It called for a ban on smoking in public schools, an end to cigarette sales in hospitals, and for separate hospital facilities for patients sensitive to cigarette smoke.

The Society also asked that physicians place "No Smoking" signs in their offices, that the government stop using tax dollars to promote the U.S. tobacco industry, and that the Federal Aviation Administration and Congress approve petitions and bills for either separate smoking compartments or smoking bans aboard commercial airliners.

Joining the Society were 60 public and private organizations comprising the D.C. Interagency Council on Smoking. In addition to all-out educational promotions, physicians and ministers staffed four five-day withdrawal clinics, sponsored by the Seventh-Day Adventist Church.

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Tepanil® Ten-tab

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Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

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ISMA Organizes Speakers Bureau

Following is a listing of Indiana State Medical Association members who comprise the ISMA Speakers Bureau.

These speakers may be contacted directly by the county or district medical society wishing their services. This also applies to professional or lay organizations who might wish to utilize the Bureau.

For additional information, contact the Headquarters Office, Indiana Sate Medical Association, 3935 N. Meridian St., Indianapolis, Indiana 46208. Telephone (317) 925-7545.

SPEAKERS BUREAU

INDIANA STATE MEDICAL ASSOCIATION

ALCOHOLISM	
Alcohol and Alcoholism	Paul M. Flanagan M.D. 3440 N. Meridian St. Indianapolis 46208
ALLERGY	
Allergy	Julian R. Kaufman, M.D. 3124 East State Blvd. Fort Wayne 46805
BLOOD DISEASES	
Blood Disorders	Laurence H. Bates, M.D. 3524 N. Meridian St. Indianapolis 46208
CANCER	
Pap Smear	William J. Pierce, M.D. Bruceville 47516
Cancer and Leukemia	Laurence H. Bates, M.D. 3524 N. Meridian St. Indianapolis 46208
Gynecologic Cancer—Diagnosis and Management	Hans E. Geisler, M.D. 5470 E. 16th St. Indianapolis 46218
Cancer—Diagnosis and Treatment	H. H. Dunham, M.D. 1025 Manchester Wabash 46992
Cancer, As Seen by a Diagnostic Radiologist	Robert W. Currie, M.D. 512 E. 57th St. Indianapolis 46220
CHILDBIRTH	
Prenatal Classes for Educated Childbirth	Thomas M. Conley, M.D. 500 Southway Blvd., East Kokomo 46901
EYE	
Contact Lenses Glaucoma General Ophthalmology	Martin Fundenberger, M.D. 2815 E. 38th St. Indianapolis 46218
GASTRO-INTESTINAL	
Diseases of the Gastrointestinal Tract, Liver and Pancreas	Stephen R. Stouder, M.D. St. Vincent's Hospital 120 W. Fall Creek Parkway Indianapolis 46208

GENERAL	
Medicine, Government, Religion Architecture—Ancient and Modern Rome Sex Dyslexia	Daniel H. Cannon, M.D. 1203 E. Spring St. New Albany 47150
Project Hope	Richard L. Westerman, M.D. Box 10 Zionsville 46077
Common Medical Problems	Raymond J. Doherty, M.D. 47 W. 68th Pl. Merrillville 46410
GENERAL PRACTICE	
Family Practice General Practice	Ross L. Egger, M.D. Daleville 47334
HEALTH CAREERS	
Allied Health Careers, Opportunities, Educational Programs, Recruitment	J. Lynn Arbogast, M.D. I.U. Medical Center Indianapolis 46202
Medical Careers	M. O. Scamahorn, M.D. Pittsboro 46167
HEART AND BLOOD VESSELS	
Diagnosing the Coronary-Prone	William J. Pierce, M.D. Bruceville 47516
Cerebral Vascular Disease	Mark L. Dyken, M.D. I.U. Medical Center Indianapolis 46202
Heart Disease in Children	Donald A. Girod, M.D. I.U. Medical Center Indianapolis 46202
Preventing Coronaries	Raymond J. Doherty, M.D. 47 W. 68th Pl. Merrillville 46410
HISTORY OF MEDICINE	
Medicine in Central Indiana, Rural 19th Century	M. O. Scamahorn, M.D. Pittsboro 46167
MEDICAL EDUCATION	
Medical Education	Stephen R. Stouder, M.D. St. Vincent's Hospital 120 W. Fall Creek Parkway Indianapolis 46208
Graduate Training in Community Hospitals	Ross L. Egger, M.D. Daleville 47334
Medical Education	Joseph M. Black, M.D. 502 W. Second St. Seymour 47274
MEDICAL — LEGAL	
Malpractice Medical Efficiency Professional Corporations Taxes	Walter Able, M.D. 2760 25th St. Columbus 47201

MEDICAL ORGANIZATION

Medical Organization	B. E. Kintner, M.D. 236 Simpson St. Elkhart 46514
General Area of Organized Medicine, Medical Education and Other Subjects	Peter R. Petrich, M.D. 401 S. Perry St. Attica 47918
Organized Medicine	Eugene S. Rifner, M.D. Van Buren 46991

MEDICAL TEACHING

Medical Teaching Interdenominational Christian Medical Center, Vellore, India	Naomi L. Dalton, M.D. 2307 E. Second St. Bloomington 47401

MENTAL HEALTH

Mental Health	B. E. Kintner, M.D. 236 Simpson St. Elkhart 46514

NEUROLOGY

Multiple Sclerosis Diseases of Muscle and Peripheral Nerves	Mark L. Dyken, M.D. I.U. Medical Center Indianapolis 46202

NUTRITION

Selected Topics in Pharmacology Nutrition	Richard L. Westerman, M.D. Box 10 Zionsville 46077

ORTHOPEDICS

Club Foot Heredity of Musculoskeletal Disorders Childrens' Orthopedics	Robert Palmer, M.D. 1255 W. 86th St. Greenbriar Professional Bldg. Indianapolis 46260
Orthopedic Subjects	Lee Cattell, M.D. 400 S. Berkley Rd. Kokomo 46901

POPULATION CONTROL

Population Control Problems	Thomas M. Conley, M.D. 500 Southway Blvd., E. Kokomo 46901
Mental Retardation and Voluntary Sterilization Population Control and Public Health Voluntary Sterilization and Family Planning	Herschel C. Moss, M.D. 1640 N. Ritter Ave. Indianapolis 46218

PREVENTIVE MEDICINE

Preventive Medicine Health Hazard Appraisal	Lewis C. Robbins, M.D. 1815 N. Capitol Ave., #302 Indianapolis 46202
Preventive Medicine Annual Physical Examinations	Frederic L. Schoen, M.D. 5717 S. Anthony Blvd. Fort Wayne 46806

PSYCHOLOGY

The Psychological Development of Children	Raymond J. Doherty, M.D. 47 W. 68th Pl. Merrillville 46410

PUBLIC HEALTH	
Air Pollution	Julian R. Kaufman, M.D. 3124 E. State Blvd. Fort Wayne 46805
Public Health	Joseph M. Black, M.D. 502 W. Second St. Seymour 47274
PUBLIC RELATIONS	
Public Relations	B. E. Kintner, M.D. 236 Simpson St. Elkhart 46514
What Lay People Should Know About Medicine	Louis F. Bradley, M.D. 303 S. Main St. Bluffton 46714
RADIOLOGY	
Diagnostic Radiology Radiology Technology	Henry H. Dunham, M.D. 1025 Manchester Wabash 46992
RELIGION	
Religion and Medicine	B. E. Kintner, M.D. 236 Simpson St. Elkhart 46514
REPRODUCTION	
Reproductive Education	Thomas M. Conley, M.D. 500 Southway Blvd., E. Kokomo 46901
SEX EDUCATION	
Sex Education	Raymond J. Doherty, M.D. 47 W. 68th Pl. Merrillville 46410
SKIN (DERMATOLOGY)	
Diseases of the Skin Tumors of the Skin	James H. Gosman, M.D. 1815 N. Capitol Ave. Indianapolis 46202
SMOKING	
Smoking and Health	Robert W. Currie, M.D. 512 E. 57th St. Indianapolis 46220
SOCIO-ECONOMIC-POLITICAL	
Medical Socio-Economics	B. E. Kintner, M.D. 236 Simpson St. Elkhart 46514
Office Practice	Frederic L. Schoen, M.D. 5717 S. Anthony Blvd. Fort Wayne 46806
Socio-Economics	Donald R. Taylor, M.D. Ball Memorial Hospital Muncie 47303
The State Legislature and Medical-Governmental Problems General Problems of State of Indiana-Education, Taxes, Roads and Highway Safety; Constitutional Amendments	Otis R. Bowen, M.D. 304 N. Center St. Bremen 46506

Politics and Medicine	B. E. Kintner, M.D. 236 Simpson St. Elkhart 46514
Legislation Medical Socio-Economics Medical Insurance Welfare	Joseph M. Black, M.D. 502 W. Second St. Seymour 47274
SPORTS AND MEDICINE	
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Hendricks County Has Plan To Get "Own" Physicians

MORE doctors now and in the future is one of the major concerns of Hendricks County physicians.

Recently, members of the county medical society met with former students of the county's high schools who are now attending Indiana University School of Medicine and other medical schools to do a "selling job" on practicing medicine in their home county following graduation.

In addition to the students, the society, whose president is John P. Calhoon, Avon, invited resident physicians of seven hospitals in Hendricks County and surrounding counties, the Hendricks County hospital administrator and hospital trustees and their wives.

Included on the evening program, following a social hour and dinner. were introductions and brief personal resumes of each student's present activity and each Hendricks County physician's practice.

Dr. M. O. Scamahorn, secretary of the local society and president-elect of the Indiana State Medical Association, reported on the history of the Hendricks County Medical Society, which was organized in 1854, five years following the formation of the ISMA.

Dr. Scamahorn preaches what he has practiced. He returned to Pittsboro following graduation from medical school and practiced medicine with his father, the late Dr. O. T. Scamahorn. One of his major interests has been the future of the young doctor and encouraging his interest in rural Indiana practice.

Among many materials which were given the young medical guests were maps of Hendricks County illustrating the locations of member doctors, a booklet describing the Hendricks County Hospital and its operation, including a list of the medical staff, its officers and committees, and booklets describing the beginning of medical practice and a business guide to medical practice.

The Indiana State Medical Association's preceptor program has paid off for Hendricks County, through the cooperation of Hendricks County physicians. Three new doctors are now practicing in the county as a result of working with local physicians as part of their undergraduate training.

As all of the doctors agree, "It was a most enjoyable evening for all and our society hopes a constructive one for medicine in our county." ◄



DR. TOM WALKER, Brownsburg, tries to do a "selling job" on practicing medicine in their home county to two medical students and their wives.

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JACK W. HICKMAN, M.D.
Indianapolis

Alcoholic Cirrhosis and Phenothiazines Don't Mix

The complications that come on with progressive alcoholic cirrhosis are well-known. Many of these prod the physician into the use of sedative drugs, and these need to be chosen carefully. The study reported by Read et al. indicates that the phenothiazine drugs must be used carefully in these patients.[1] The authors studied the effects of chlorpromazine in 29 cirrhotic patients and 33 controls. They found EEG and clinical changes in the cirrhotic patients that indicated an increased sensitivity to the drug. They speculate that this effect may be due to a slower rate of metabolism of chlorpromazine by the sick liver, but the present study does not go into this question specifically. These authors stress to us, as others have done, that drug metabolism in the sick is not always the same as in the healthy person.

Australian Antigen in Acute Viral Hepatitis

Every time we turn around someone is finding Australian-SH antigen in a group of people, or not finding it. Cossart et al. report detecting this antigen in the sera of 11 of 27 patients with acute viral hepatitis admitted to their hospital in London.[2] It has been somewhat difficult to follow the progress of knowledge regarding Australian antigen because of the division of patients into "serum" and "infectious" hepatitis groupings. The present report makes no attempt to separate these two categories. We can be sure that similar reports on this antigen will continue to appear, and it does look as if its discovery and elucidation will be important in understanding disease mechanisms.

Prostatic Ca—Estrogen—Liver Failure Syndrome

Kontturi and Sotaniemi report briefly a rather interesting study from Finland.[3] These authors studied liver function tests in 24 patients who had verified diagnosis of carcinoma of the prostate and were receiving rather large doses of estrogens. All patients had been castrated and were receiving large daily doses of synthetic estrogens. They found that SGOT, SGPT and BSP values all showed degrees of hepatic dysfunction in 30-50% of the patients within two weeks after estrogens were instituted. These values all tended to return to normal after therapy was continued for four to 12 months, however. The authors stress that this information should be of value to physicians treating these patients, and is of particular value in the patient who has had prior hepatic disease. These patients may be particularly sensitive to the hepatic effects of such therapy.

* * *

REFERENCES

1. Read, A. E., Laidlaw, J., McCarthy, C. F.: Effects of Chlorpromazine in Patients with Hepatic Disease, *Brit. Med. J.* 3:497-499, No. 5669.
2. Cossart, Y., Taylor, P. E., Vahrman, J., Zuckerman, A. J.: Australian-SH Antigen in Hepatitis Patients in London, *Brit. Med. J.* 3:755-756, No. 5673.
3. Kontturi, M., Sotaniemi, E.: Effect of Oestrogen on Liver Function of Prostatic Cancer Patients, *Brit. Med. J.* 4:204-205, No. 5677. ◄

From *The Journal* 50 Years Ago

Within recent years the etiology of disturbed thyroid function has been the object of renewed interest. It has been quite generally accepted belief that the causative factor of goiter (with or without disturbed function) is most frequently conveyed to the human organism through drinking water. By what means goiterigenous waters acquire their harmful properties and to what constituents their toxic effects are due, are questions that have never been satisfactorily answered. Magnesium, iron and copper pyrites; the degree of hardness; the content of iodin, carbon dioxid, salt or absorbed air, have all been suggested, but adequate proof of their causal relationship is lacking. Some evidence has been adduced to show that water derived from certain geologic formations is most frequently the bearer of the toxic constituents. Radioactivity and the presence of an organic ferment have also been suggested and some experimental evidence brought forward to strengthen the contention.

The evidence developed in recent years is of interest because it tends to show that goiter is the result of a living infective agent, most commonly transmitted through water and soil, but not exclusively. I wish to emphasize particularly the following experiments and clinical observations in support of this theory. McCarrison fed the residue separated by filtration from goiterigenous water to young men and produced goiter about 15 days from the beginning of the experiment. He further treated 100 cases of endemic goiter by 10 gr. doses of thymol night and morning, greatly benefiting or curing the majority, concluding that the intestnal tract was the seat of the infection. Ebstein, Hammeter and Messerli had similar results. Lactic acid ferments produced marked improvement. Vaccines containing most of the bacteria of the intestinal flora; containing a predominant bacillus of the colon group, and even exogenous vaccines, were used successfully . . . . Miles F. Porter, Jr., M.D., Fort Wayne, "Hyperactivity of the Thyroid," *JISMA*, September, 1920.

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See Clinical Considerations section on last page...

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Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe	**Resistant/ Moderately Severe**	**Serious/Life-Threatening**
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

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Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentrations of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

Adverse Reactions: The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

For more complete prescribing details, consult package insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07083.

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AHFS CATEGORY 8:12.28 S-02



ABSTRACTS, BOOK REVIEWS

MUTATION AS CELLULAR PROCESS

Edited by G. E. W. Wolstenholme and Maeve O'Connor, Ciba Foundation Symposium, J. & A. Churchill, Ltd., London, 1969; 244 pages; $9.00.

Mutagens and mutants make a right bonny broth: especially since the quantum jump year in which the helix structure was unveiled to the fascinated audience of world science. The editorial chairman of this particular gathering, Prof. R. F. Kimbal, is very pithy in presenting the problems being mulled over, "mutation is not just an isolated event . . . or a simple chemical reaction, but a process in which cellular functions are intimately involved." He goes on to state, "We can recognize at least the following main steps: (1) initiation, (2) fixation, (3) detection. Initiation necessitates molecular alteration of the chromosome."

The two dozen plus experts go into a very intense and highly technical discussion of how the output can be modified by various input variables—as, e.g., by ultraviolet irradiation or hydroxylamine lesions—and just what makes the alteration from phenotypic to genotypic. Altogether, we have the presentation of the very latest in a very rapidly developing field.

This is an interim report for the adornment of hospital library shelves. I cannot see the average M.D.—or even the farily advanced scholar in the area—perusing this monograph often. As usual, the binding, printing and editing are top level. The Ciba Foundation is to be congratulated on its continuing efforts in this most challenging arena.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

GAS CHROMATOGRAPHY IN BIOLOGY AND MEDICINE

Ciba Foundation Symposium, edited by Ruth Porter, J. & A. Churchill, Ltd., London, 1969; 213 pages with 67 illustrations; price not stated.

There has been a veritable spate of articles and monographs analyzing the developing technics of gas chromatography. Most of the material has been aimed at the expert in the field. It is a relief to scan a *symposium* that is also directed at the M.D. who will be ordering these tests: firstly and lastly.

The chapter headings practically tell the story as it unfolds. The background is clearly and succinctly summarized. Then, we are told just what these procedures can do now and what can be expected in the reasonably near future. It is intriguing to realize that—since World War II—the quantity of sample needed has been reduced by a factor of 10^{12}! The laboratory equipment is illustrated in fashion quite understandable to the average M.D. (you and me). We are made aware of the fact that we should be able to get rapid reports (within the hour or less) on blood sample analyses giving precise levels of poisons and partition coefficients previously unattainable: a consummation greatly to be applauded.

The printing, binding and typing are up to the usual standards; a few typographical errors are really insignificant. Thus, on page 20, a couple of letters in the word, commercial, are transposed; so what? Altogether, a most commendable effort well worth your time!

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

Abstracts From Various Literature, Prepared by AMA

GASTROSCHISIS WITH ANTENATAL EVISCERATION

W. D. Widmann (Army General Hospital, Frankfurt, APO N.Y. 09757)

Amer. J. Dis. Child. 119:478-480, (June), 1970.

Gastroschisis (cleft abdomen) is a rare congenital anomaly of unknown etiology in which there is a para-umbilical full-thickness defect of a portion of the abdominal wall. A normal umbilicus and umbilical cord are found either adjacent to the defect or separated from it by a narrow margin of skin. A case is presented in which a reinforced silastic pouch was created initially, and then reduced in size in three stages and finally removed, with full-thickness closure of the abdominal wall achieved by 15 days of age. The physiologic advantages of this procedure include prevention of further bacterial contamination and of heat and fluid loss by covering the eviscerated viscera. Also, there is no significant elevation of the intra-abdominal pressure, as would be produced by tight initial skin closure. Follow-up at eight months of age revealed no ventral hernia and no signs of bowel dysfunction.

PERFORATED DUODENAL ULCER: LONG-TERM FOLLOW-UP

G. J. Nemanich and D. M. Nicoloff (University of Minnesota Health Sciences Center, Minneapolis)

Surgery 67:727-734, (May), 1970.

A retrospective study was made of 104 patients who had a perforated duodenal ulcer. Eighty-five patients were treated surgically initially; 79 had simple closure of the duodenal perforation. A recurrence rate of peptic ulcer symptoms was noted in 61.6% and subsequent operations were required in 43% of the 60 patients followed. A high postoperative mortality rate occurred in the group treated with simple closure. Six patients had definitive surgery such as vagotomy and pyloroplasty initially for their duodenal perforation and the results in this group were excellent.

SUGAR CONSUMPTION AND CIGARETTE SMOKING

A. E. Bennett, R. Doll (13 Norham Gardens, Oxford, England), and R. W. Howell

Lancet 1:1011-1014, (May 16), 1970.

Data from inquiries of three groups of men—hospital patients, employees, and a random population sample—show evidence of a strong positive association between cigarette smoking and sugar intake. Heavy cigarette smoking is positively associated with an increase in the number of cups of hot drinks consumed daily and the amount of sugar consumed. This is independent of age and social class: for smokers of five to 14 and 25 or more cig-

Continued

Continued

arettes per day there is in one investigation a statistically significant increase in sugar consumption independent of beverage consumption or social class. Much of the correlation between smoking and sugar consumption can be accounted for by a positive association with consumption of hot drinks. These inquiries afford further evidence that cigarette smoking and not sugar consumption is implicated in the etiology and manifestation of myocardial infarction.

URETERIC ENURESIS: ECTOPIC URETERAL INSERTION IN WOMEN

F. Boeminghaus and W. Schmitz (Urologische Klinik der Universitat, Dusseldorf, West Germany)

Deutsch Med. Wschr. 95:1227-1229, (May 29), 1970.

Ten cases of ureteric enuresis in women are reported. The condition is not rare and is due to congenital ectopic insertion of the ureter below the external bladder sphincter, resulting in urinary incontinence. Wetting generally occurs during the day but bladder emptying is quite normal. There is no typical urine smell but infection of the ureter can cause vaginal fluor which is difficult to treat. Usually the ectopic ureter originates from a double kidney and can be demonstrated in the intravenous pyelogram. Location of the ectopic orifice can sometimes be made by intravenous injection of indigo carmine or vaginography. The therapeutic method of choice is heminephrectomy with resection of the upper double-kidney portion and the relevant ureter. If the kidney is normal the ectopic ureter should be implanted into the bladder.

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3. The HANGER organization has more employees and more certified fitters than any other prosthetic manufacturer.
4. HANGER wearers are guaranteed HANGER service and repairs at 39 HANGER offices from coast to coast.
5. HANGER research is working actively on new prosthetic developments for the benefit of all amputees.

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416 N. Main St., Evansville, Ind. 47711

IRREVERSIBLE COMA AND CEREBRAL DEATH

J. Gaches et al. (Hospital de la Salpetriere, Paris)

Sem. Hop. Paris 46:1487-1497, (May 8), 1970.

Coma of traumatic or vascular origin was studied in 71 patients to establish the chronological point at which EEG activity ceased and its relation to clinical signs which were evident at that time. When some indication of complete irreversible coma was present, verification by EEG, on the scalp for a relatively short time, made diagnosis accurate. When clinical signs were absent, however, the EEG silence did not necessarily correspond with complete irreversible coma or cerebral death since respiration often continued. Stereoencephalography, angiography, measurement of cerebral output and biopsy were used to affirm cerebral death or the possiblity of recovery. The appearance of a flat EEG tracing for 24 hours is a time interval which most authors agree constitutes cerebral death. This study concurred with this finding, but suggested the most accurate sign of irreversible coma or cerebral death was cessation of spontaneous respiration and the necessity of respiratory assistance.

"HOOK CATHETER" TECHNIC FOR TRANSFEMORAL REMOVAL OF FOREIGN BODY FROM RIGHT SIDE OF THE HEART

P. Rossi (St. Vincent's Hospital, New York)

Amer. J. Roentgen 109:101-106, (May), 1970.

The use of a hook catheter to remove a "lost tubular foreign body" within the vascular system may obviate major surgical intervention. The catheter method is easy to perform, atraumatic, and has been used successfully on two occasions without post-procedural complications.

SAFETY OF DIAGNOSTIC ULTRASOUND IN OBSTETRICS

I. Donald et al. (Queen Mother's Hospital, Glasgow, Scotland)

Lancet 1:1133-1134, (May 30), 1970.

Ultrasound examinations were carried out on 1,114 apparently normal pregnant women at various stages of pregnancy and with differing ultrasonic frequencies throughout. The incidence of fetal abnormality in the group was 2.7%. Neither the time in gestation of the first examination nor the number of examinations seemed to increase the risk of fetal abnormality.

AMANTADINE IN PARKINSONISM

K. R. Hunter et al. (G. M. Steen, University College Hospital Medical School, London)

Lancet 1:1127-1129, (May 30), 1970.

In a controlled trial, seventeen patients with parkinsonism were given 200 mg daily of amantadine hydrochloride. A small beneficial effect on physical signs occurred, but no significant effect on functional disabilities. Improvement in physical signs was maintained for eight weeks but several patients noted deterioration in functional performance after two to five weeks of treatment. Amantadine has only slight therapeutic effects compared with L-dopa.

RADIATION DOSE EFFECTS IN RELATION TO OBSTETRIC X-RAYS AND CHILDHOOD CANCERS

A. Stewart and G. W. Kneale (Department of Social Science, Oxford University, Oxford, England)

Lancet 1:1185-1188, (June 6), 1970.

Epidemiological data from the Oxford Survey of Childhood

Cancers were analyzed in respect of in-utero exposure to x-rays during obstetric investigations. The risk of cancer was greatest when exposure was during the first trimester and was directly related to the fetal dose. This dose-response relationship fits in with a previously published hypothesis that cancers caused in this way are due to the propagation of one cell whose controlling gene had experienced a small but irreversible change at the moment of x-ray exposure.

HEXACHLOROPHANE FOR TREATING CARRIERS OF *STAPHYLOCOCCUS AUREUS*

P. Noone, R. J. Griffiths, and C. E. D. Taylor (Central Middlesex Hospital, London)

Lancet 1:1202-1204, (June 6), 1970.

Twenty nasal carriers of epidemic strains of *Staphylococcus aureus* most of which were resistant to several antibiotics, including some resistant to cloxacillin, were treated with 2% hexachlorophane cream applied to the nose twice daily for seven days. *S aureus* was eradicated from all provided that 2% hexachlorophane soap was used concurrently. After treatment, coagulase-negative staphylococci were isolated from each patient; *Proteus mirabilis* was isolated from three, and *P mirabilis* and *Pseudomonas aeruginosa* from one.

FIBROADENOMAS IN PATIENTS RECEIVING ORAL CONTRACEPTIVES

R. E. Fechner (Methodist Hospital, Houston)

Amer. J. Clin. Path. 53:857-864, (June), 1970.

The ratio of fibroadenomas to fibrocystic disease and mammary carcinoma has remained virtually the same at the author's hospital for the past 17 years. This time interval includes the five years before and the 12 years after the introduction of oral contraceptives. Histologic specimens of 54 fibroadenomas from patients receiving oral contraceptives included four with acinar hyperplasia similar to fibroadenomas of pregnancy. Marked epithelial hyperplasia was seen in the breast tissue adjacent to fibroadenomas from three women in the 20- to 30-year age bracket. Its appearance was similar to that of the hyperplasia seen in fibrocystic disease and may have been fortuitous. Examination of the remaining tumors and adjacent breast tissue from patients taking oral contraceptives disclosed no qualitative difference from 54 control fibroadenomas removed before the availability of these hormones.

INTERACTION OF COMMONLY PRESCRIBED DRUGS AND WARFARIN

D. S. Robinson (University of Vermont College of Medicine, Burlington) and D. Sylvester

Ann. Intern. Med. 72:853-856, (June), 1970.

The recognition of drugs that interact with warfarin has clinical relevance because of potential serious reactions as a result of the complexities of multiple drug therapy. Because of their frequent use in patients requiring anticoagulant therapy, four drugs—chlordiazepoxide, secobarbital, amobarbital, and chlorothiazide—were studied in eight subjects for possible interaction with warfarin. The administration of hypnotic doses of both barbiturates, secobarbital and amobarbital, significantly accelerated the plasma disappearance and decreased the hypoprothrombinemic effect of warfarin. Neither chlordiazepoxide nor chlorothiazide, administered in standard doses, caused significant alterations in warfarin's action or metabolism. An analysis of variance of the data failed to detect any other effects due to sex, time of year or sequence of the drugs during the treatment periods. Drugs that can be used safely with warfarin without risk of unpredictable fluctuations in its pharmacologic effect need to be identified. ◄



Changes in Blue Shield Payment Patterns

(One of a series prepared by Blue Shield)

The pattern of benefits offered by Indiana Blue Shield has changed as dramatically over the last 20 years as the practice of medicine itself. Payments to physicians have increased from $1,432,415 in 1949 to more than $40,000,000 last year. During this period proportionately more has been dispensed for non-surgical benefits.

In 1949, almost all benefits were surgical (63%) or maternity (36%). Last year surgical benefits, though considerably increased in dollar amounts, accounted for 40%, and maternity for 13%. Meanwhile medical care benefits have increased vastly, and categories which did not exist in 1949 (psychiatric care, anesthesia, diagnostic tests and Medicare supplement) have become important covered benefits for Blue Shield members.

This demand for expanded benefits is expected to continue in the future, as members seek the broadest possible protection in the health care field.

MEDICAL CLASSIFICATION	AMOUNT PAID 1949	1969
SURGICAL:		
T & A	$ 144,955	$ 890,518
Eye, Ear, Nose & Throat	72,388	1,839,522
Appendectomy	205,840	477,830
Hernia	42,690	835,522
Abdominal	91,910	1,659,822
Proctology & Urology	109,518	2,011,134
Orthopedics	114,395	2,875,634
Radiation Therapy	9,786	337,244
All Other Surgical	110,903	5,248,178
Total Surgical	$ 902,386	$16,175,404
PSYCHIATRIC:	*	$ 243,605
MEDICAL:	$ 8,411	$ 4,720,864
MATERNITY:		
Deliveries	$ 259,764	2,878,551
Gynecology	261,854	2,496,428
Total Maternity	$ 521,618	$ 5,374,979
ANESTHESIA:	*	$ 2,939,694
DIAGNOSTIC:	*	$ 6,062,207
MEDICARE SUPPLEMENT:	—	$ 4,876,029
GRAND TOTAL	$1,432,415	$40,392,782

* These benefits were not available in 1949.

Role of Business in Shaping Environment

"The free enterprise system cannot continue to succeed if private business is not willing to play a role in shaping our environment as well as responding to it. . . . Most important in long-range corporate planning is to put the urban problems on the organization chart."—G. William Miller, president, Textron, Inc.



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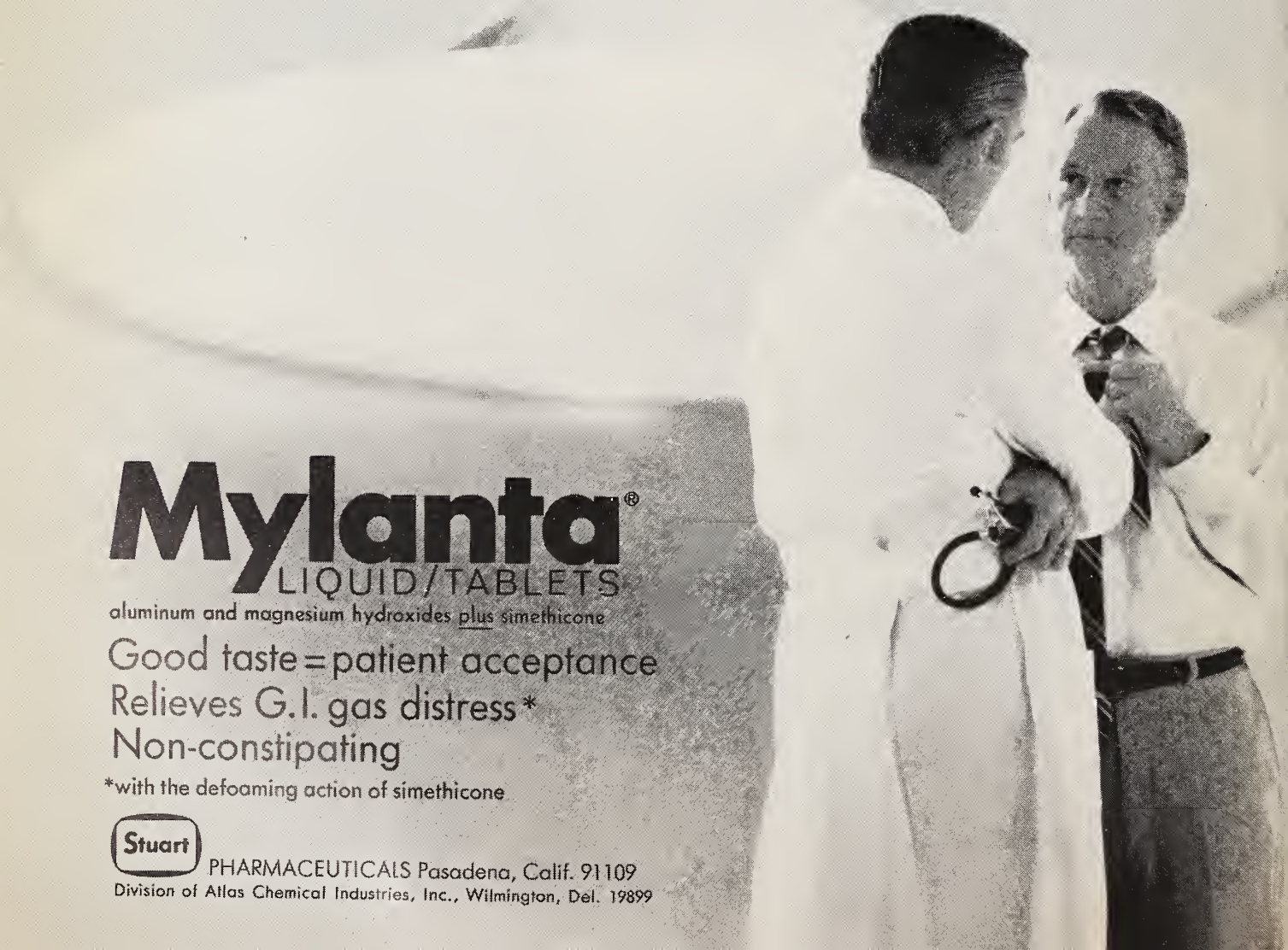
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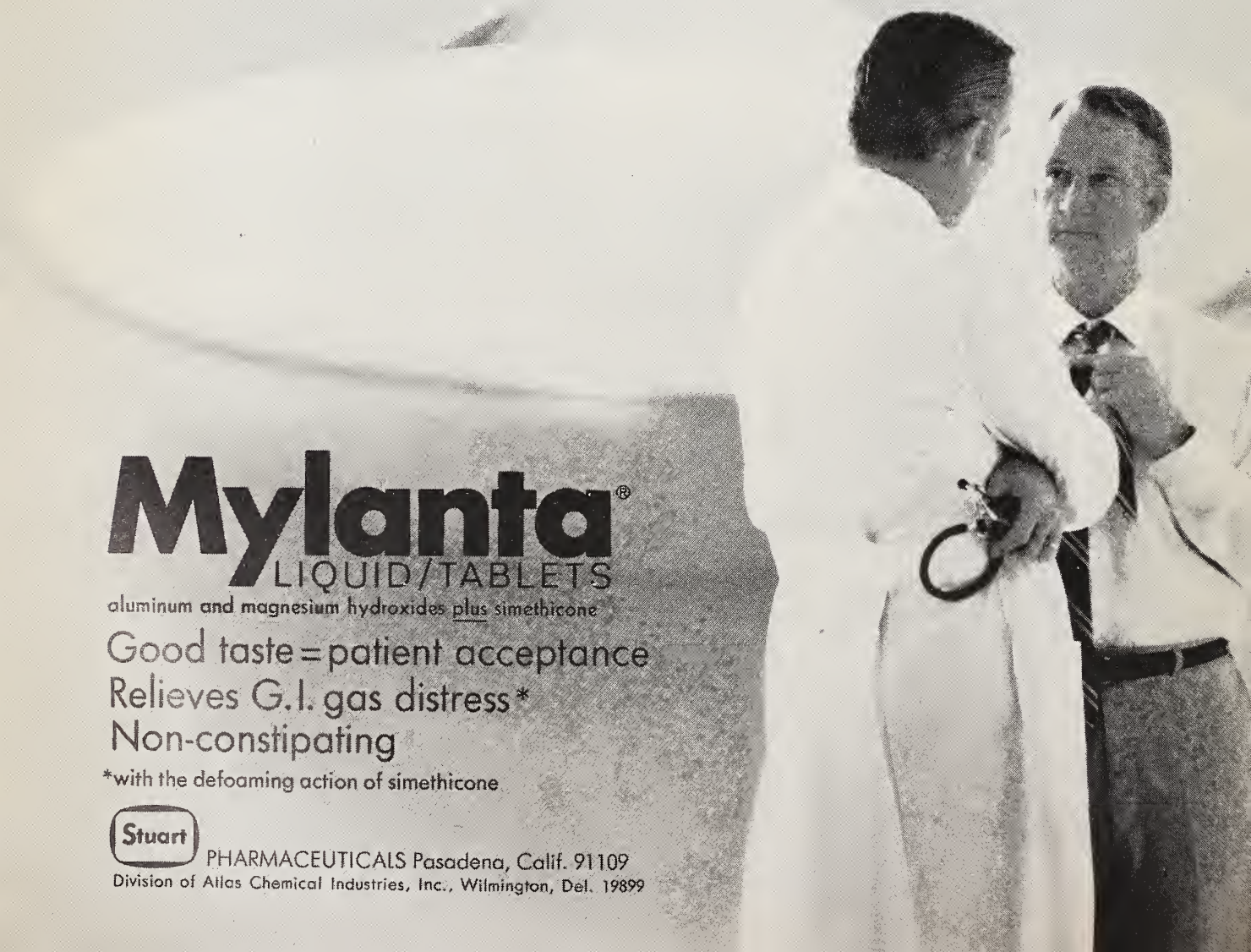
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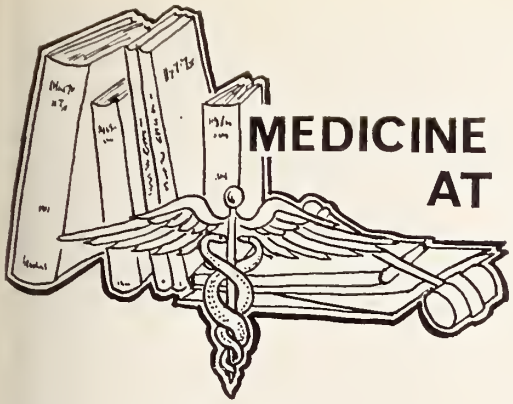
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MEDICINE AT LAW

M'Naghten and "Irresistible Impulse" Rules in Indiana—An instruction given by a trial court in a prosecution for murder was upheld by the Indiana Supreme Court. The instruction sufficiently set forth the M'Naghten rule and the idea of irresistible impulse.

Under Indiana law, an instruction on insanity is required to set forth the following ideas: (1) that the accused could know and comprehend the nature and consequences of his act; the nature of the act includes knowledge on the accused's part that the act was wrong; (2) that the accused had sufficient power to control his impulse to commit the act charged.

The trial court gave the following instruction: "In determining the effect of irresistible impulse, a person that has sufficient mental capacity to know right from wrong and be able to understand the nature and consequence of his act, whose will power is not so impaired by a diseased mind so that he can resist an impulse to kill another person, there is not mental unsoundness of mind in the eyes of the law. In other words, if the will of such a person is simply overborne by ungoverned passion or temper and is not the result of a diseased mind then criminal responsibility results from his criminal act." The instruction adequately stated the two necessary ideas.—*Brewer v. State of Indiana,* 252 N.E.2d 429 (Ind. Sup. Ct., Nov. 14, 1969).

Surgeon's Liability for Pregnancy After Sterilization—After a difficult third childbirth, a surgeon recommended and performed a sterilization operation on the mother. Later, the patient bore a healthy child, after an uneventful pregnancy. The normal birth, a Florida appeals court held, did not bar the mother's claim for damages against the surgeon for breach of warranty and negligence.

The child is not to be thought of as "unwanted or unloved," but as "unplanned," the appeals court stated, reversing the trial court's dismissal of the suit. It also pointed out that performance of a sterilization operation is not against public policy and that there was no question that there would be an action against the surgeon if the suit had been brought before delivery. Recovery should not be defeated because suit was filed after the birth of the child, the court said.

The court did not pass on the amount of damages, as this was a question for the jury if the patient could prove her case. *Jackson v. Anderson,* 230 So.2d 503 (Fla. Dist. Ct. of App., Jan. 9, 1970; rehearing denied, Feb. 13, 1970).

Suggestions for Reducing Mishaps in Hospital Operating Room—The negligence occurring in hospital operating rooms that leads to malpractice suits was discussed in a medicolegal quarterly. Over 75% of the doctors sued for malpractice are surgeons, the article states. Approximately 80 to 90% of such suits find their origin in the operating room or in incidents directly traceable to the operating room.

The author contends that the great majority of operating room mishaps resulting in malpractice suits concern death in the operating room, absence of a recovery room or mishaps therein, missing instruments or sponges, explosions in the operating suite, anesthesia mortality, infections, surgery performed on the wrong patient, and improper consent to surgery.

The author advances a number of ways in which the possibility of a malpractice suit can be reduced. Before the patient enters the hospital, the doctor should emphasize to the patient that the hospital care and treatment is under his supervision and is an extension of the treatment the doctor has instituted in his office. When the doctor visits the patient at the hospital after admission, he should tell him the medical plan for the diagnosis and treatment of the illness, disease, or injury. If special tests are to be taken the patient should be informed of them and given the reasons for their being taken.

During the patient's hospital stay the doctor should act as the mediator between the patient and the hospital. These courtesies enable the patient to understand more lucidly the hospital routine and, thereby, the patient tends to minimize complaints.

The hospital, to be surgically safe and legally protected, must always be on the alert to the constant threat of the sources of malpractice and negligence in the operating suite. A preventive operating room program should be set up, centered around adequate nursing supervision of the surgical suite, and containing an up-to-date, properly equipped department of anesthesia with a full time M.D. anesthesiologist in charge of both anesthesia and recovery room.

The recovery room should be under the immediate surveillance of a regis-

Continued

tered nurse supervisor. A complete and properly functioning intensive care unit, as part of the recovery room or as a separate section, should be available under proper medical and nursing supervision for the seriously ill postsurgical patient.

Cardiac arrest teams, available for immediate activation, with the most facile implementation possible, should be available. Proper postoperative nursing care, with written instructions from the surgeon to the nurse explicitly spelled out, is also a potent weapon against the accusation of negligence.—*Hospital Operating Room and The Law*, by Bernard J. Ficarra, 16 Medical Trial Technique Quarterly, No. 1, p. 13 (Sept. 1969) and p. 25 (Dec. 1969), published by Callaghan and Company, 165 North Archer Avenue, Mundelein, Ill. 60060.

Legal Aspects of Artificial Insemination—The legal uncertainties which surround artifical donor insemination (A.I.D.) have plagued doctors who are involved with this technique. In a law review article, a doctor with considerable experience in this practice discusses legal problems connected with A.I.D.

Two questions raised by the use of A.I.D. are whether the child born as a result of this method is legitimate and whether the mother of such a child is legally an adulteress. The author finds no distinct pattern in the legal decisions of cases dealing with either of these issues. The courts of one state appear to condemn both the mother and the child, while those of another state seem to condone the practice and protect both its participants and the child created thereby.

A hopeful note is sounded by the decision of the last state court to hear such a case. In that instance, the highest court of California, in 1967, noted what it considered to be absurdities in considering artificial insemination as an adulterous act. The court supported the legitimate status of the child.

Of even more positive significance to proponents of A.I.D. are the actions of the state legislatures of Georgia and Oklahoma, which in 1964 and 1967 respectively, enacted legislation which specifically declared artificial insemination not to be an act of adultery.

Significant opposition has been directed at the A.I.D. practice by organized religions, particularly the Roman Catholic Church, the Church of England, and Orthodox Jewry. The author notes in conclusion that both religion and law were slow to view donor insemination in its proper perspective. The law has confused donor insemination with adultery and has labeled the infant so conceived as a bastard. Actually, the author argues, A.I.D. was introduced to avoid illict relations to achieve pregnancy in the marriage of a fertile wife to a sterile husband.—*Artificial Insemination*, by Alan F. Guttmacher, 18 De Paul Law Review Nos. 2 and 3, p. 566 (Summer, 1969), published by De Paul University College of Law, 25 E. Jackson Blvd., Chicago, Ill. 60604.

Insurance Company Liable for Charges Paid by Medicare—A patient is entitled to payment from her insurance company for hospital charges even though they are paid directly to the hospital by Medicare. The wording of the hospitalization policy, promising payment for expenses "actually incurred," the Louisiana appeals court said, includes Medicare-covered charges, because the patient, as well as the government, was liable.

The Court, in awarding judgment, distinguished cases where hospital services were rendered by the government to a member of the military, or where medical services were administered to a physician. In these cases, no charges were ever made, so none were "actually incurred." In the instant case, a charge was made to the patient by the hospital on its books, and the insurance company was liable, whether paid by Medicare or not.—*Niles v. American Bankers Insurance Company*, 229 So.2d 435 (La. Ct. of App., Dec. 18, 1969; rehearing denied, Jan. 7. 1970).

Photograph of Auto Crash Victim Inadmissible—In a suit to recover damages for injuries sustained in an automobile accident, a photograph of the victim taken in the operating room was properly excluded from evidence as being likely to inflame and prejudice the jury, an Illinois appellate court ruled.

The color photograph showed the patient's head with a rubber and metal pipelike device inserted between his lips, his eyes closed, and his face covered with what appeared to be blood and a dark mucus-type substance. The court said the picture was gory and hideous by anyone's standards.

The victim contended that the photograph should have been admitted into evidence because his physician needed it to illustrate to the jury how he treated the injuries. At the trial, the physician explained that the nose and the surrounding tissue had been torn and that he had to reconstruct the nose. However, because the photograph was so ghastly, the court felt that it would bias the jury against the party accused of negligent driving.

Two other photographs showing the patient's face with scars after healing were properly admitted, the reviewing court commented.—*Hulsebus v. Russian*, 254 N.E. 2d 184 (Ill. App. Ct., Dec. 19, 1969).

Photograph of Injuries Admissible—In a woman's suit for injuries sustained in an automobile accident, a trial court did not abuse its discretion in admitting in evidence a photograph of the injuries to her face, a Michigan appellate court

ruled. The photograph was taken immediately after her arrival at the hospital following the accident. The photograph's probative value with respect to material issues in the case outweighed any prejudicial effect that it might have.

The photograph showed the woman's face covered with blood and a mass of small and large and jagged lacerations, her nose smashed and almost completely torn from its position.

The admissibility of a photograph is for the sound discretion of the trial court. A photograph must, of course, be accurate and have probative value. The photograph must also be helpful in throwing light upon some material point in issue.

One issue before the trial court was the extent of the woman's injuries and the amount of pain and suffering that they caused her. Another issue was the amount of recovery for medical expenses incurred in treating the injuries. The photograph was necessary for a proper description of the injuries and for an explanation of the corrective treatment employed by the plastic surgeon. The photograph was thus clearly of probative value on material issues of fact. No question was raised as to the photograph's accuracy.

The negligent driver contended that the photograph should have been excluded because it was prejudicial and inflammatory.

The court said that the photograph was admittedly gruesome. However, its probative value on material issues outweighed any prejudicial effect that it might have.—*Anderson v. Lippes*, 170 N.W.2d 908 (Mich. Ct. of App., June 26, 1969).

Discovery Doctrine May Apply to Surgical Accident—A woman patient's suit against a physician who allegedly severed her bile duct during gallbladder surgery was improperly dismissed by the trial court for failure to bring suit within the state's two-year statute of limitations for negligence cases, a New Jersey appellate court ruled. Even though the suit was filed more than two years after the date of the operation, the evidence raised a question of fact as to whether the two-year period started on the date of the surgery or the date the patient discovered the injury.

On January 17, 1964, the patient underwent an operation for removal of her gallbladder. On the second day after the operation, the patient observed that a large quantum of bile was staining, saturating, and seeping through the padding covering her surgical incision. She also had attendant pain in the right side of her back. The heavy drainage persisted throughout her stay in the hospital.

When questioned by the patient, her physician attributed the unusual, heavy bile drainage to a loosening of a suture at the cystic duct, notwithstanding that he had never seen a suture loosen at the cystic duct.

By January 27th, when the time for the patient's discharge was at hand, and the drainage had not stopped, the physician ordered an intravenous cholangiogram. Because the dye used had not been properly absorbed so as to permit visualization, the x-rays were negative.

By this time, the physician recommended that the patient be examined by someone with more experience. Accordingly, the patient was discharged and then admitted to a second hospital under a referred physician's care. In an operation performed on February 3, 1964, the referred physician discovered that the common bile duct had previously been completely severed.

At the trial, the patient testified that, after the second operation, the referred physician told her only that her bile duct had been found to be "interrupted." She thought he also said there was a stone in the duct. The patient further testified that she did not discover her true condition until sometime during the first half of 1966, when she visited the second hospital for further x-rays. On October 6th of that year she filed suit against the original physician.

In seeking dismissal of the complaint, the physician argued that the complaint was barred because it had not been filed within two years of the date of the operation, as required by the state's two-year statute of limitations. The trial court granted the request for dismissal.

The two-year statute of limiations does not begin to run until the patient knows or has reason to know of the injury and its negligent cause. In reversing the trial court, the appellate court held that the patient should be afforded the opportunity to establish to the jury that she first knew, or had reason to know, of the physician's severance of her common bile duct within a period of two years prior to the start of the suit. The court did point out, however, that there was no dispute that the common bile duct was severed, so that the lapse of time in filing suit did not entail the ordinary danger of a false or frivolous claim, or one which was speculative or uncertain.—*Yerzy v. Levine*, 260 A.2d 533 (N.J. Super. Ct. App. Div., Jan. 15, 1970).

Liability for Missing Sponges—Three cases illustrating the problem of sponges inadvertently left in the patient after surgery were discussed in an article in a hospital association journal.

In the first case, a surgeon was held liable because he had failed to note the 12-inch long metal sponge-holder, either attached to the sponge or separated from it. The court of appeals in this Lousiana case held that his failure was his own negligence, as distinguished from the nurses' counting error, thus holding the surgeon, as well as the hospital liable. The lower court, from which this appeal was taken, held that the nurses were not servants of the surgeon; they were under his control during surgery, but not for the pur-

Continued

pose of making a sponge count, which was considered part of the hospital's procedure, so that the surgeon was not bound by the failure of the nurses to account for all sponges.

The second case, decided in Texas, held to the traditional "captain of the ship" doctrine, holding the surgeon liable for those in the operating room working under his control. This included the nurses who miscounted. It should be noted that, when this suit was filed, nonprofit hospitals in Texas were not liable for the negligence of their personnel if chosen with reasonable care. Therefore, the patient, in order to recover any damages, had to bring suit against the surgeon.

The final case involved two physicians bringing an action against a hospital after they had been sued by their patient. It was their contention that if they were held liable it was because of the negligence of the hospital and its operating room personnel.

The issue here was whether the physicians and the hospital were joint tortfeasors—co-equals in guilt—or had the relationship of primarily negligent and secondarily parties. Since financial contribution among joint tortfeasors was not permitted under Nebraska law, the physicians demanded indemnification from the hospital, contending that their liability resulted from "technical fault," while the true negligence was committed by hospital personnel and therefore attributable to the hospital.

A federal appellate court in Nebraska concurred with the position taken by the physicians and held that indemnity should be allowed where one is not really negligent, but, because of his relationship to the wrongdoer, attempts to recover from the negligent party.

The question of whether the physicians were only technically negligent or were as negligent as the hospital (losing the right to indemnification) was a question that would have to be resolved at the subsequent trial.—*The Sponge Count*, by Arthur H. Bernstein, 44 Journal of the American Hospital Association, No. 1, p. 122 (Jan. 1, 1970), published by the American Hospital Association, 840 N. Lake Shore Dr., Chicago, Ill. 60611.

Chronic Alcoholic Not Immune from Punishment—A chronic alcoholic, convicted of public drunkenness, was being punished, not because of his physiological condition, but for performing an act forbidden to a person while in an intoxicated state, ruled a federal appellate court. A California statute forbids a person in a state of extreme intoxication to appear in a public place. The federal appellate court upheld the conviction of the alcoholic by a state trial court.

The chronic alcoholic was seen staggering down the street early in the morning. He then proceeded to climb into a stranger's parked automobile. A policeman who had observed this behavior arrested him for public drunkenness and he was convicted.

On appeal, the alcoholic argued that the infliction of a criminal penalty for being drunk is cruel and unusual punishment and, therefore, in violation of the eighth amendment of the United States Constitution. The federal court rejected this argument stating that he was not being punished for being drunk but was being punished for being in a public place while in a drunken state.

The alcoholic also argued that the California public drunkenness statute was so vague that an ordinary person could not tell if he would be in violation of the law. The federal court also rejected this argument, noting that the statute was clear and contained simple, ordinary language which could be understood by an ordinary person. The judgment of the state trial court was affirmed—*Budd v. Madigan*, 418 F.2d 1032 (C.A. 9, Nov. 12, 1969). ◄

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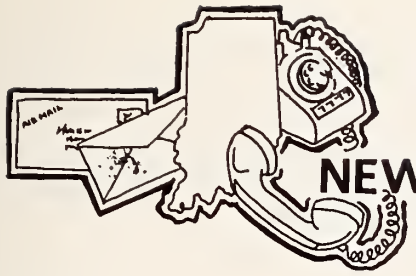
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NEWS NOTES

ERRATUM

A News Note which was carried on p. 962 of the August issue of *The Journal* about Dr. Thomas Hamilton, Columbia City, speaking to the Southern Indiana Association of Chiropractors, was completely erroneous. Dr. Hamilton is a medical doctor only and the newspaper clipping from which the News Note was taken was written about a Dr. Thomas Hamilton who is a chiropractor in Boonville.

***The Journal* apologizes to Dr. Hamilton and regrets any embarrassment caused by the error.**

ISMA and AMA Cosponsoring Lectures on Medical Science

The AMA Council on Foods and Nutrition and the ISMA are cosponsoring lectures on medical sciences at ten Indiana universities and colleges this academic year. The purpose of the lectures is to inform students and faculty of recent developments and to stimulate interest in the medical sciences.

Dr. Clarence Cohn, Director of the Division of Nutritional Sciences, Michael Reese Hospital will talk at Ball State on February 9 and at Earlham on February 10.

Dr. Laurence M. Hursh, Director of Health Service, University of Illinois, will speak at St. Joseph's on October 5, at Indiana State (Terre Haute) on December 9, at Purdue on February 23 and at an unspecified date at DePauw.

Dr. Richard J. Jones, Associate Professor of Medicine, Pritzker School of Medicine will speak at Notre Dame on October 13, at Manchester on February 1 and at Saint Mary's College in Notre Dame on February 2.

Dr. Steen Speaks

Dr. Lowell H. Steen is participating in the AMA Third National Congress on Medical Ethics this month appearing on a panel on "The Ethical Physician." Dr. Steen's subject is "Does not OVERcharge, OVERutilize, OVERprescribe."

Speaks at Dinner

Dr. Lain Tetrick, Portage, was guest speaker at a meeting of the Calumet Industrial Nurses recently at Highland. Topic of his talk was "Dear Hearts."

Speaks to Nurses

Dr. John Krueger, Fort Wayne, spoke at the 49th commencement exercises of St. Joseph's Hospital School of Nursing recently. **Dr. Jack Patterson** presented a scholastic achievement award during the ceremonies.

Dr. Engel is Author

Dr. Edgar L. Engel, Evansville, is the author of an article in a current issue of *Redbook Magazine*. Dr. Engel's article is entitled "The Expectant Mother."

Series of Training Seminars Conducted in Coal Mining Areas

The American College of Radiology is conducting a series of training seminars in coal mining areas to improve the diagnosis of early pneumoconiosis. Up to 200 radiologists will attend each session for two days.

The 1969 coal mine safety act requires x-ray examinations on all underground coal miners. The College is cooperating with the Public Health Service by organizing the training sessions.

On Panel

Dr. Floyd B. Coleman, Waterloo, appeared on a panel discussing drugs recently before a public meeting in the DeKalb County courthouse at Auburn.

Comments on Film

A new film concerning heart trouble and how to avoid it was shown at Indiana State University's Tirey Memorial Union recently in Terre Haute. **Dr. William G. Bannon** commented on the film and answered questions following the film.

Dr. Lloyd Named

Dr. Frank P. Lloyd, Indianapolis, has been appointed chairman of the Indiana State Advisory Committee to the United States Commission on Civil Rights. Dr. Lloyd is vice-president of the Marion County Metropolitan Plan Commission, and a member of the National Urban Coalition and the health committee of the National Urban League.

Attends Course

Dr. Charles W. Magnuson, South Bend, recently attended an American College of Physicians postgraduate course on "Gastroenterology for Clinical Teachers" at the University of Michigan at Ann Arbor.

U.S.P. Revision Committee Organizes Subcommittees for 1970-1975

The Pharmacopeial revision program for 1970-1975 started its work recently by organizing its Revision Committee into twelve subcommittees.

The Scope Subcommittee, which chooses the drugs to be added, has, as one of its members, Tom S. Miya, Ph.D., of West Lafayette, Indiana. Dr. Miya is also a member of the Subcommittees on Posology and Related Information and on Biologics and Related Products. John M. Woodside of Indianapolis is a member of the Subcommittee on Antibiotics and Natural Products.

Dr. Land at Nebraska

Dr. Francis L. Land, formerly of Fort Wayne, has joined the University of Nebraska College of Medicine Division of Family Practice. After leaving Fort Wayne, Dr. Land was Commissioner of the Medical Services Administration, Social Security and Rehabilitation Service, in Washington, D.C.

Dr. Farquhar Named Chairman

Dr. John S. Farquhar, Fort Wayne, has been named chairman of the AMA's Emergency Medical Services Committee. Dr.

Continued

Continued

Farquhar will be responsible for maintaining communications between the federal government and the state and local medical societies.

New Officers Named

The Indiana Roentgen Society, Inc., has elected new officers. They are: **Drs. Marvin N. Golper, Kokomo,** president; **Donald R. Taylor, Muncie,** president-elect and **Dale B. Parshall, Elkhart,** secretary.

New Pamphlet Reports Noise Causes Physical and Mental Ills

"Noise—The Third Pollution" is the title of Public Affairs Pamphlet No. 449. It explains what noise is and what it does—physically and psychologically—and what you and the community can do to quiet our society.

The pamphlet is sold by Public Affairs Committte, 381 Park Ave., South, New York City 10016, at 25 cents a copy.

Dr. Slaughter Quoted

Dr. and Mrs. John C. Slaughter, Evansville, were recognized in a recent issue of *Reader's Digest* for coming up with an idea of helping others during their vacation. Dr. Slaughter and his wife founded the Holidays for Humanities eight years ago. It arranges for physicians, dentists, nurses and technicians to spend their vacations ministering to back-country regions in Central and South America and a number of Caribbean islands.

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Drug Dangers

A program on drug abuse designed to acquaint junior and senior high school pupils in Vigo County with the dangers involved in the use of drugs was conducted recently in Terre Haute. Physician speakers on the program, which was spread over two months, included: **Drs. Fred Dierdorf, Paul Siebenmorgan, Robert Brown and William Scully.**

Addresses Society

"Care and Education of Retarded Children in Europe" was the topic of a program of slides and an address in Anderson recently for a meeting of the Madison County Association for Retarded Children. **Dr. Ladislas D. Wojcik,** pediatrician at the Davis Clinic in Marion, was the principal speaker. He recently toured Europe and observed work in behalf of retarded children in several countries.

Dr. John Schechter on Medical Mission at Vietnamese Dispensary

Dr. John Schechter, Indianapolis, is one of three U.S. Army medical officers of the Americal Division who are contributing to the medical care of Vietnamese civilians by assisting in the Dickey Chapelle Memorial Dispensary in the village of An Ton.

Almost all Vietnamese physicians are on military duty and care of civilians must be accomplished by the services of doctors' assistants. The dispensary at An Ton is staffed by 21 midwife-nurses and one male nurse who has had three years of medical training. They see 3000 patients each month.

Dr. Schechter and two other officers visit the facility in turn and help with the difficult cases, instruct the personnel in medical procedures and perform minor operations as needed Their advice and counsel is intended to improve the work of the Vietnamese in the dispensary without making them dependent on outside help.

Dr. Kerr Speaks

"Urology" was the topic chosen by **Dr. John Kerr, Michigan City,** when he addressed the monthly meeting of Division No. 6 of the Indiana State Licensed Practical Nurses Association recently at St. Anthony's Hospital.

Dr. McCalla Elected

Dr. Charles X. McCalla, Paoli, has been elected a Fellow of the American Society of Abdominal Surgeons.

Attends Convention

Dr. James Miller, Wakarusa, recently attended a medical convention sponsored by the University of Minnesota at Ft. Lauderdale, Fla.

Speaks to Alumni

Dr. Bryant A. Bloss, Evansville, was guest speaker at a meeting of the Deaconess Hospital Alumni Association recently. He spoke on "Arthritis of the Hip."

St. Mary's Hospital, Evansville, Honors Dr. Herman Baker on Retirement

Dr. Herman Baker was honored and St. Mary's Hospital of Evansville was enriched when, on July 1, the hospital library was dedicated as the Herman M. Baker Medical Library. The date was chosen as the anniversary of Dr. Baker's first day as an intern at St. Mary's in 1910.

Dr. Baker retired this summer--that is he is closing his office and will devote as much time as possible to the Rehabilitation Center, in which he has always been interested, and to clinical teaching at the hospital.

Winners Named in Monroe County AAPS Essay Contest

Susan Baker of the ninth grade of Dyer School, Bloomington, won first place in the AAPS Essay Contest for her essay on "The Advantages of the American Free Enterprise System over Communism." The contest was sponsored by doctors of Monroe County.

Kristine Weathers, ninth grade, Edgewood High School, received second place; Cindy Henderson, seventh grade, Dyer School, won third place. All three essays are being entered in the national contest.

Dr. Shroyer Honored

Dr. Herbert L. Shroyer, Dunkirk, was honored recently by an "Appreciation Day" in his home town. There was a special Jay County Medical Society luncheon, an afternoon parade and an entertainment program in the evening.

Physical Fitness Program

A program on physical fitness was presented recently for members of the Winamac Kiwanis club. Speakers included **Drs. Charles Heinsen, Winamac,** and **E. L. Hollenberg, Hagerstown.** Both physicians stressed the value of exercise in the fight against heart disease.

On Program

Dr. James H. Gosman, Indianapolis, chairman of the board of directors of the Indiana Division of the American Cancer Society, appeared on the program of the Third Annual Cured Cancer Assembly recently in Indianapolis.

Dr. Bowman Speaks

Dr. John A. Bowman, medical director of the Howard County Guidance Center, spoke on "Alcoholism" at a recent meeting at the Kokomo Rescue Mission. The Rescue Mission is staging a campaign to raise money for an Alcoholic Rehabilitation Center.

Leads Group

The second in the First United Methodist Church series on the theme "Man Alive" was held recently in Anderson. **Dr. Charles King** led one of three interest groups on the theme "Sex—Another World or the Edge of Night," exploring the meaning of sexuality, the roles of men and women and relations for life.

Speaks at Gary

Dr. Edward A. Tyler, Indianapolis, spoke on human sexual behavior and sex education at a recent medical seminar for physicians and other medcial personnel at Methodist Hospital in Gary recently. **Dr. Wei-Ping Loh, Gary,** and Norman J. Wilson, Crown Point, were co-moderators for the seminar.

Physician Honored

Dr. Harold Erickson, Windfall, was honored recently at the annual Windfall PTO athletic and music dinner. Dr. Erickson was presented a plaque in appreciation of his community spirit and work with the community's residents.

The Second Class of Certified Medical Representatives Graduates

The second class of the Certified Medical Representatives Institute was graduated on April 30. The Institute, located in Roanoke, Virginia, conducts a two and one-half year educational program for pharmaceutical representatives.

All course study is related to the career functions of the students in their work with ethical drug manufacturers. Representatives of Ciba, A. H. Robins, Warner-Chilcott, Syntex and Dorsey Laboratories were members of this year's class.

Named to Fellowship

Dr. Donald T. Olson, director of medical education at Memorial Hospital, South Bend, has been named a Fellow of the American College of Cardiology. Also named a Fellow was **Dr. Morton E. Tavel, Indianapolis.**

On Panel

Dr. Robert W. Price, Elkhart, appeared on a panel discussion on drug abuse recently at the Oaklawn Psychiatric Center there.

Dr. Gitlin Honored

Dr. William A. Gitlin, Bluffton, has been awarded a Community Service Award for his activities in civic affairs. Dr. Gitlin is a member of the school board, jail and county home physician, and a former coroner and health officer.

Two More Sections Published From Framingham Heart Study

Two more sections have been published in a monograph series intended to inform the profession of the lessons drawn from the Framingham Heart Study.

Section 23, "Serum Cholesterol, Systolic Blood Pressure, and Framingham Relative Weight as Discriminators of Cardiovascular Disease," is now available at $1.75. Section 24, "Diet and the Regulation of Serum Cholesterol", can be had for 75 cents.

Write the Superintendent of Documents, U. S. Government Printing Office, Washington D.C. 20402.

Dr. Caylor Visits

Dr. Harold Caylor, Bluffton, recently returned from visiting missionary doctors who had previously taken training at the Bluffton Clinic. He visited **Dr. Don Rudy** in Rhodesia, **Dr. Robert Simpson** in Mozambique and **Dr. Ernest Steury** in Kenya. In each visit, Dr. Caylor assisted his former colleague in surgery.

Direct Programs

Three members of the Krannert Institute of Cardiology at Indianapolis directed programs at the recent American College of Cardiology sessions in New Orleans. **Dr. Charles Fisch,** professor of medicine and director of the Krannert Institute, was in charge of the four-day scientific program involving 500 teachers exploring new developments in cardiology. **Dr. Suzanne Knoebel** and **Dr. Gary Anderson** of the institute directed cardiologists in diagnostic and patient management proficiency. Other participants were **Drs. Harris Shumacker, Walter Daly, Kalman Greenspan, Harvey Feigenbaum, James Dillon, William Nasser, Paul McHenry, Richard Davis, Robert Edmands, William Elliott and Ed Ross.**

Speaks to Lions

Dr. Copeland Bowers, Kokomo, spoke on his visit to the Philippines at a recent meeting of the Kokomo Lions Club.

Continued

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NEWS NOTES

Continued

Smith Kline and French Releases 1970/71 Edition of Services Catalog

Smith Kline and French Laboratories has released the 1970/71 edition of *SK&F Services Catalog.* It catalogs medical films, booklets, pamphlets, periodicals, and the "Code 4" cardiopulmonary resuscitation training program.

Copies may be obtained from the SK&F representative or by writing the company at 1500 Spring Garden St., Philadelphia 19101.

Speaks on Drug Abuse

Dr. John M. Records, Franklin, spoke on drug abuse recently before the Future Homemakers of America and interested students at the Franklin High School. Dr. Records' address was given in conjunction with the Kiwanis "Operation Drug Alert," co-sponsored by the local Kiwanis and the Woman's Auxiliary to the American Medical Association.

"The Pill" is Topic

Dr. Clarence Boone, Gary, spoke on the investigation into the pros and cons of oral contraceptives and how they affected operation of Planned Parenthood clinics recently at Gary. He spoke before the annual dinner of the Planned Parenthood Association of Northwest Indiana.

Speak at Symposium

The second annual Vance G. Page Memorial Cancer Symposium was held recently in the Bloomington High School Auditorium with a panel of 10 Bloomington physicians giving talks, showing films and answering questions. The speakers included: **Drs. Cyrus Houshmand, James Milan, G. D. Ley, R. F. Robison, Anthony Pizzo, W. J. Stangle, J. J. Schaffer, Brad Bomba, P. T. Holland and P. J. Wenzler.**

New Federal Source Book Now Available to Physicians

Copies of "A Federal Source Book: Answers to the Most Frequently Asked Questions About Drug Abuse" may be obtained at 25 cents each from the Superintendent of Documents (Dept. D), Government Printing Office, Washington, D.C. 20402.

Speaks to Nurses

Dr. DeWayne L. Hull, Fort Wayne specialist in reconstructive and plastic surgery, spoke on "Trauma to the Hand" before a recent meeting of the Fort Wayne Industrial Nurses Association, Inc.

Dr. Schmidt Speaker

Dr. Loren F. Schmidt, Indianapolis, presented color slides and told of his recent missionary service in Bolivia at the First Church of the Nazarene recently at Terre Haute.

Leukemia is Topic

Dr. Thomas Troeger, South Bend, spoke on "The Diagnosis and Treatment of Leukemia" at a meeting of the North Central District, Indiana Society of Medical Technologists, recently at South Bend.

Continued



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phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
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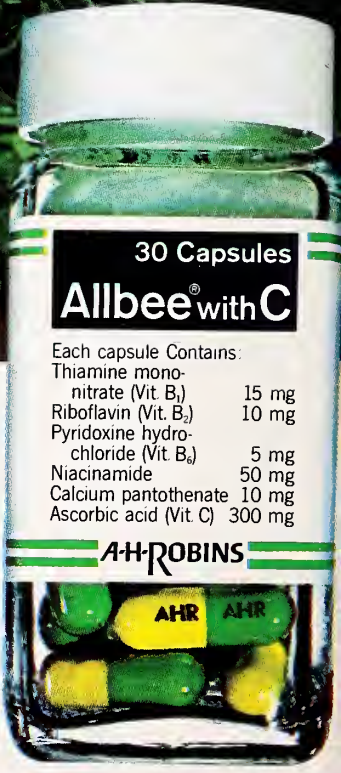
Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

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NEWS NOTES

Continued

Elected Director

T. H. Lake, President of Eli Lilly International Corporation, has been elected a Director of the Royal Society of Medicine Foundation.

The Foundation is an American corporation which enables physicians who have had at least two years of research experience or special training to associate with colleagues in their area of particular interest in university hospitals and research centers in Great Britain. Eight young American physicians were recently awarded traveling scholarships of $2500 each for three months' study.

Half-time Fellowships in Adolescent Psychiatry Offered

Half-time fellowships in adolescent psychiatry are being offered by the Jewish Board of Guardians of New York City.

Physicians who have completed a three-year residency in adult psychiatry and wish to spend half their time in practice are eligible. The stipend is $7500 for each of two years.

Write to Dr. Aaron H. Esman, Director of Training, Jewish Board of Guardians, 120 W. 57th St., New York City 10019.

"Establishing a Medical Practice" Title of New Booklet for Physicians

"Establishing a Medical Practice" is the title of a 16-page booklet published by the Bank of America National Trust & Savings Association for the information of physicians in the process of chosing a site for practice.

The discussion includes the kind of practice, community location, office location, office planning and equipment, financial planning, non-medical professional consultants to aid in planning, professional insurance and physician's aides. Also included are tips on medical records, financial records, billing and the setting of fees and collection problems.

Single copies are obtainable by writing Area Development Department, Bank of America NT & SA, World Headquarters Bldg., San Francisco 94120.

PMA Produces New Booklet

The Pharmaceutical Manufacturers Association has just published a booklet "Molecules, Medicines and You" to describe research activities in molecular biology.

It is written in lay language, has 16 pages and several full color illustrations. A bibliography lists 22 books on health sciences.

Single copies are available on request from the Association, at 1155 Fifteenth St., N.W., Washington, D.C. 20005.

New District Manager

David L. Wagoner, of Eaton Laboratories, recently sales representative in South Bend and Elkhart, has been named district manager, with headquarters in Chicago.

Three New Booklets by Fire Protection Association Available

Information important to hospital and nursing home staffs in regard to fire protection is available in two booklets published by the National Fire Protection Association.

No. 10 "Standard for the Installation of Portable Fire Extinguishers" and No. 10A "Recommended Good Practice for the Maintenance and Use of Portable Fire Extinguishers" are available at $1.00 each.

"Standard for Nonflammable Medical Gas Systems" is the title of a 28-page booklet also published by the National Fire Protection Association. Copies of the 1970 edition of this booklet (NFPA No. 56F) may be obtained at 75 cents each. Write the Association at 60 Batterymarch St., Boston 02110. ◄

AMA Publishes Congressional Directory

An invaluable guide to physicians and to all citizens interested in good government and its workings is the *1969 Congressional Directory* to the 91st Congress developed by the Division of Public Affairs of the American Medical Association.

This handy, pocketsize booklet lists alphabetically each state's senators and representatives, their office room numbers, building, switchboard number and individual extensions.

It also features Senate and House Committees and their memberships and phone numbers for the committee offices, and also the names and means of contact for "officials in the Executive Branch of importance to medicine."

Only a limited supply remains, but single copies are available upon request from the Division of Public Affairs, AMA, 535 North Dearborn Street, Chicago, Ill. 60610.

What is worth doing..



In 1936 A. E. Smith, professional at Woolcombe, England, recorded the lowest golf score for an 18 hole course. He shot a 55 and was 15 under par. The course at Woolcombe, which measured 4,248 yards, was covered in 4, 2, 3, 4, 2, 4, 3, 4, 3 out and 2, 3, 3, 3, 3, 2, 5, 4, 1 in.

is worth doing well.

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INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—July, 1970

Disease	July 1970	June 1970	May 1970	July 1969	July 1968
Animal Bites	1470	1313	1477	1408	1220
Chickenpox	36	111	471	105	49
Conjunctivitis	157	142	129	150	103
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	26	25	14	25	7
Gonorrhea	824	697	715	707	521
Impetigo	171	95	90	212	108
Infectious Hepatitis	45	46	80	32	47
Infectious Mononucleosis	44	56	121	33	25
Influenza	206	321	734	237	78
Measles					
Rubeola	22	16	53	14	22
Rubella	77	117	351	75	27
Meningococcic Meningitis	0	1	5	1	0
Meningitis, Other	3	0	3	3	2
Mumps	103	191	337	99	100
Pertussis (Whooping Cough)	15	13	17	9	15
Pneumonia	209	275	482	173	126
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	455	460	844	416	311
Syphilis					
Primary & Secondary	38	35	35	33	20
All Other Syphilis	170	150	168	117	58
Tinea Capitis	1	7	1	8	8
Tuberculosis (Active)	102	73	76	81	83

Radiologists Warn Against Chiropractic

With special emphasis on the hazards of improperly used x-rays and radiation, The American College of Radiology joins other scientific and medical groups in stating that the practice of chiropractic "constitutes a dubious benefit to patients who seek health care."

According to a resolution approved by the Board of Chancellors and Council of the College this past February, "chiropractic training does not adequately cover the use of ionizing radiation for detecting disease and injury."

The College warns that the methods of making x-ray exposures discussed in some chiropractic texts is "contrary to the established fundamentals of good radiation safety and sound medical practice."

Physicians should advise their patients that the American College of Radiology regards the use of radiation by chiropractors as "unwarranted and without likelihood of significant medical gain."



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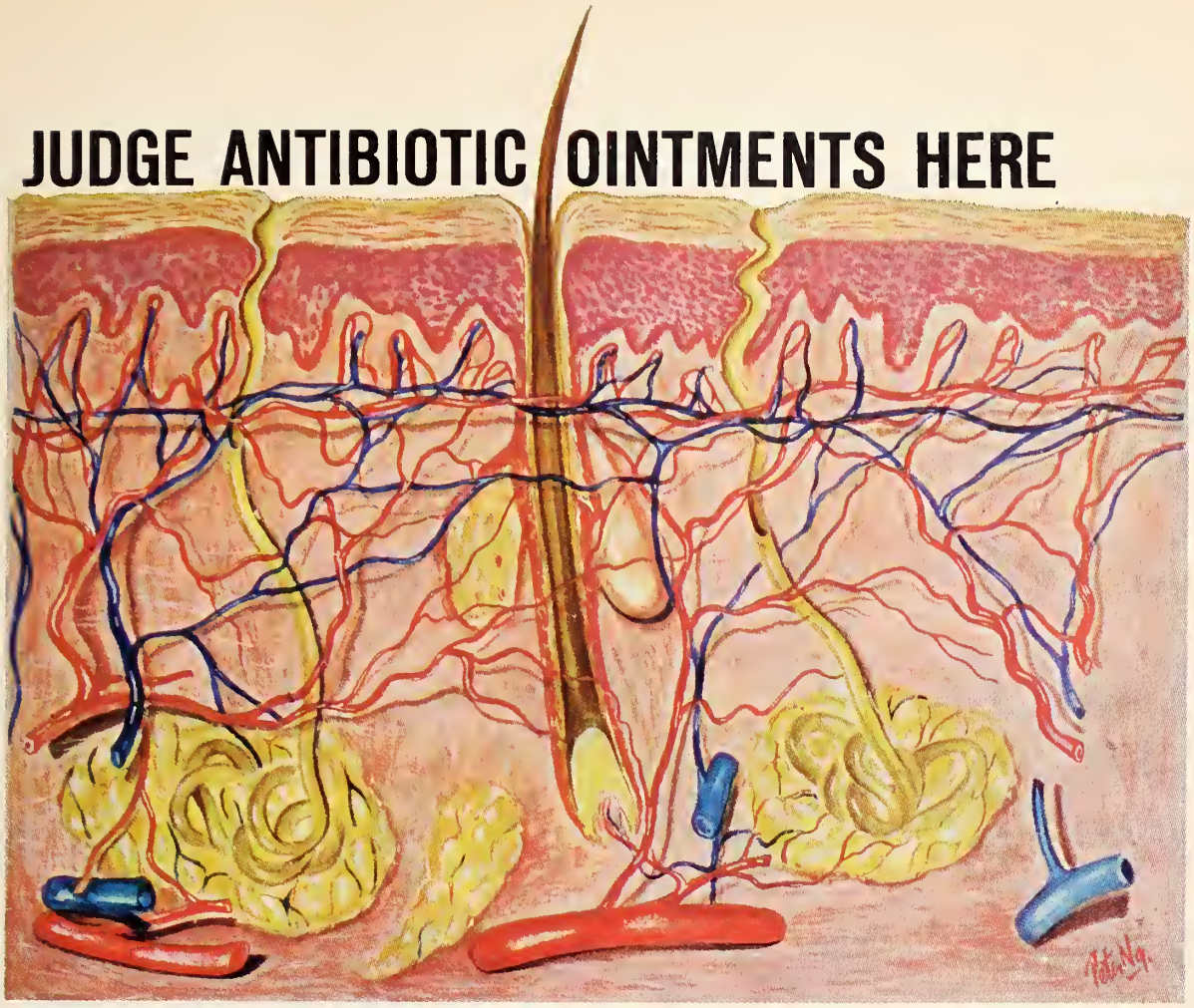
Maybe. Maybe not. In any case she needs something to control her sneezing, watery eyes and runny nose. And for most children over six, Novahistine® LP can be depended on to provide fast relief from summer colds and allergy. These continuous-release tablets have a vasoconstrictor-antihistamine formulation that begins working in minutes, then continues to provide relief for hours. A single Novahistine LP tablet, morning and evening, can keep most young patients free of symptoms all day and all night. Use with caution in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

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POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Clinical Extension of a pure Smooth Muscle Relaxant

TROCINATE®

Brand THIPHENAMIL HCl

400 mg./100 mg. S/C tablets

Trocinate relaxes all smooth muscles. Its direct action (musculotropic) does not involve the autonomic nervous system and it is not mydriatic. It is metabolized by the body and eliminated in the urine as harmless degradation products. Trocinate has a remarkable history of freedom from side-effects.

When a pure direct-acting smooth muscle relaxant is indicated, Trocinate is the drug of choice.

DIARRHEA (functional) . . . *the first 400 mg. tablet usually relieves the discomfort of diarrhea so promptly that it ceases to be a bother.*

DIVERTICULITIS—MUCOUS COLITIS . . . *the accompanying discomforts can be relieved by this direct smooth muscle relaxant.*

BLADDER SPASM . . . *relaxation is immediate. One or two tablets condition the bladder for cystoscopy in one hour.*

SPASTIC URETER . . . *the specific relaxing effect of Trocinate on the spastic ureter has been proven by animal studies and affirmed clinically. (J. Urol. 73:487-93)*

PRESCRIBING INFORMATION

WARNING: Do not give in advanced kidney or liver disease. PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. DOSAGE: 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.*

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of Ethical Pharmaceuticals

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CLINICAL CONVENTION
Date Nov. 29-Dec. 2, 1970
Place Boston, Mass.

INDIANA ACADEMY OF GENERAL PRACTICE
Date April 20-22, 1971
Place Indianapolis Hilton

INDIANA PUBLIC HEALTH ASSOCIATION
Date April 20-22, 1971
Place Indianapolis Stouffer Inn

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA ROENTGEN SOCIETY
Date March 14, 1971
Place Holiday Inn East, Indianapolis

INDIANA PSYCHIATRIC SOCIETY
Date Second Wednesday of September, November, January, February, March and April
Place For time and place, inquire Wesley A. Kissel, M.D., 1815 N. Capitol Ave., Indianapolis 46202

INDIANA STATE ASSOCIATION OF MEDICAL ASSISTANTS
Date April 23-25, 1971
Place LaSalle Motor Inn, South Bend

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 4-6, 1971
Place French Lick Sheraton, French Lick

ASSOCIATION OF OPERATING ROOM TECHNICIANS
Date Oct. 3, 1970
Place Marion County General Hospital, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 12-15, 1970
Place South Bend

INDIANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS
Date May 12-13, 1971
Place Indianapolis Stouffer Inn

THE INDIANA SOCIETY OF INTERNAL MEDICINE
Date October 14-15, 1970
Place South Bend

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY
Date Oct. 21, 1970
Place Atkinson Hotel, Indianapolis

INDIANA ASSOCIATION OF PATHOLOGISTS
Date December 5, 1970
Place Indianapolis Motor Speedway Motel, Indianapolis

Maternity Care
Infant Care
Adoption Placement
Since 1894



The Suemma Coleman Home
512 EAST MINNESOTA STREET
INDIANAPOLIS, INDIANA 46203

What's New?

White Laboratories announces two new anti-inflammatory ophthalmic solutions—Optimyd and Optival. The first is a combination of prednisolone and sulfacetamide to suppress the exudative phase of inflammatory conditions and provide bacteriostatic action. Optival is a 0.5% solution of prednisolone. Both are available in 5 cc. unbreakable plastic squeeze bottles.

* * *

Ortho Diagnostics announces a second price cut for RhoGam™ in less than a year. The new price of $35.10 a dose represents a reduction of almost 50% in the price at which it first became generally available.

* * *

Posey has a new hand restraint called the Net-Back Mitt. It is designed with a rigid palm to prevent the patient from using his fingers for grasping. The back of the mitt is nylon net. It may be used with or without a strap for attaching the mitt to the bed rail.

* * *

Lilly has added a new form of Ilosone.® It is Ilosone Liquid 250 (250 mg. per 5-cc. teaspoonful)—twice the strength of Ilosone Liquid 125. Refrigeration is required.

* * *

Metal Dynamics has an Automatic Wheel Chair Lift which enables an attendant to raise the patient, while still in the chair, for treatment. The chair may then be tilted automatically as though he had been transferred to a dental chair. The device operates on a 110 volt motor and has a dental-type head support for attachment to the wheel chair.

* * *

Fairfield announces a new cystoscope which features a new Contour-Optic™ lens system. Fiber optic illumination is built into the telescopes rather than the sheaths to focus uniform high intensity light on the field of vision. The sheaths are of stainless steel and may be autoclaved.

* * *

Dallons Instruments has a new modernistic desk and console for the observation station in intensive care units. Each unit is designed for a two-bed system. Included are temperature monitor, heart rate monitor, cardioscope, automatic central station for manual switching and also automatic switching and recording during an alarm. Also included is a memory tape loop, a closed circuit monitor for observing the patient from the desk, an EKG, a device for sending EKG and other information over phone lines, and a magnetic tape training device.

* * *

The Moore Wheel Company has a new device which will convert a standard wheelchair into a rocker. The two curved rockers are joined together at the proper gauge and have a grooved upper surface into which the four chair wheels may be rolled and then locked in place. Moore also has a built-in motor attachment which will provide constant adjustable rocking for special purposes.

* * *

Owen Labs is introducing an electric meter which is highly sensitive and portable and is designed to detect electrical current leaks in hospital instruments. Deadly electric potentials may be built up in faulty electrical equipment in hospitals. The new meter is useful for checking all instruments before they are connected to patients. It will also check leakages between different types of instruments, between an instrument and bedposts, pipes, faucets, radios and any other real or potential source of stray currents.

* * *

Will Ross has a newly developed "mini" irrigation set designed for single use. It is priced so that it can be considered as disposable. It consists of a clear barrel with smooth catheter tip, syringe bulb, and a 550 cc. graduate. Packaged in sterile condition—20 to the case.

* * *

The Harris Calorific Company of Cleveland offers a plastic laryngoscope which costs a third less than metal models. The material is softer than metal and not so apt to injure tissue. The instrument can be sterilized by boiling or by ethylene oxide. Its one piece design requires fewer electrical contact points. It is named the Penlon laryngoscope.

* * *

Recurrent streptococcal infections in children, usually treated by penicillin, have been found by a group of pediatricians in Rochester, New York, to be more effectively treated by Lincocin (lincomycin hydrochloride monohydrate, Upjohn). The advantage exists not only in the primary treatment but also in the therapy of recurrent attacks.

* * *

Drugs being studied as interferon inducers may also be of value in boosting antibody levels, when added to virus vaccines. One inducer, known as Poly I:C, when combined with a peanut oil adjuvant in an experimental flu vaccine, produced up to 64 times more antibodies than the conventional aqueous vaccines, according to Dr. Maurice R. Hilleman of the Merck Institute for Therapeutic Research.

* * *

Ayerst Laboratories have a new higher potency dosage form of Grisactin®. The increasing use of griseofulvin in a 500 mg. dosage strength prompted the new 500 mg. tablet for once-a-day dosage.

* * *

Upjohn scientists have reported the development of a long-lasting immunosuppressive drug, effective for a long time after a single injection. It is derived from cytarabine which has the same effect but requires multiple daily injections. The new compound is named adamantoyl cytarabine. Approximately 20% of the mice injected once with it had no detectable antibody 10 days after immunization. ◄

FUTURE MEETINGS, SEMINARS, COURSES

Seventh Annual OB-GYN—IAGP Symposium Will be October 28

The Seventh Annual OB-GYN - IAGP Symposium will be held this year on Ocobter 28 at the Airport Holiday Inn, Indianapolis.

Some of the topics to be discussed at the morning session include: "Asphyxia Neonatorum," "Nutrition in Pregnancy," "Management of the RH Sensitized Pregnancy and Infant" and "Hypnosis in the Daily Practice of OB-GYN."

The afternoon session will feature speakers on "Daylight Obstetrics," and "Sex Education—Home or School?" Further information may be obtained by writing the Indiana Academy of General Practice, 700 N. Alabama St., Indianapolis 46204.

Albert B. Chandler Medical Center Offers Two Postgraduate Courses

The Albert B. Chandler Medical Center at Lexington, Kentucky, will conduct a postgraduate course on October 17 and 18 on the subject of "Clinical Demonstration of Common Skin Problems." The fee is $30.

A postgraduate cardiology course will be given at the medical center on October 23 and 24 on "Listening, Deciding, Doing." Fee for this course is $60. Write Dr. Frank Lemon, University of Kentucky, Lexington 40506 for further information.

"What's New in Cardiology" Theme For 17th Western Cardiac Conference

The 17th Western Cardiac Conference will be held at the University of Colorado Medical Center in Denver on October 21, 22 and 23. The fee for out-of-state participants is $35. For further information write Colorado Heart Association, 1375 Delaware St., Denver 80204.

Pediatric Cardiology Postgraduate Course Presented in Florida in December

A pediatric cardiology postgraduate course on "Congenital and Acquired Heart Disease in Infants and Children" will be presented at the University of Florida College of Medicine, St. Petersburg Beach, on December 9 to 12.

For registration forms write to Dr. Gerald Hughes, P. O. Box 1034, Evanston, Illinois 60204.

Interstate Postgraduate Medical Assembly Will Meet in November

The Interstate Postgraduate Medical Assembly will meet at the Palmer House, Chicago, on November 2 to 5.

The program gives its usual broad coverage on clinical medicine and surgery with lectures by authorities who are selected for their skill in platform presentations.

Dr. William R. Kirtley, Indianapolis, will speak on "Choice of Agents for Diabetes Therapy" on Nov. 4. Twenty-eight other lectures, in addition to color television on clinical subjects and an interesting entertainment schedule for the ladies, are included.

Two-Day Workshop Scheduled on "The Doctor and His Changing Community"

A two-day workshop on "The Doctor and His Changing Community," sponsored by The Institute of Medicine of Chicago, will be held November 20 and 21 at Chicago's Ambassador West Hotel.

The workshop's program participants will discuss new roles and challenges facing the health professions, preparing the physician of the future, organizing community health care programs, government's role and the economics of community health care.

Principal speakers include Roger O. Egeberg, M.D., Assistant Secretary for Health and Scientific Affairs of the U.S. Department of Health, Education, and Welfare; Gerald D. Dorman, M.D., immediate past president of the American Medical Association; George E. Miller, M.D., Director of the Center for Educational Development, College of Medicine, University of Illinois, and the Hon. Charles H. Percy, senior U.S. Senator of Illinois.

Registration, which includes lunch and dinner, is $35 for members of The Institute of Medicine of Chicago, and $50 for nonmembers.

Reservations may be made by writing or calling The Institute of Medicine of Chicago, 332 South Michigan Avenue, Chicago, Ill., telephone (312) 663-0040.

Conference on Delivery of Health Services Set for October 2-3 in Indianapolis

A conference on the delivery of health services in the future will be conducted on October 2 and 3 at the Harry Wood High School, 501 S. Meridian St., Indianapolis, by Indiana University Medical Center and cooperating local community agencies.

Nationally recognized speakers will participate. Special discussion will relate to the neighborhood health center. For more information write Miss Leona Adam, R.N., 1232 W. Michigan St., Indianapolis 46202.

Chicago Medical Society Sets Two Week-long Postgraduate Courses

Two postgraduate courses of one week each in internal medicine and obstetrics and gynecology have been announced by the Chicago Medical Society. The course in internal medicine will run from November 9-13, and obstetrics and gynecology from November 16-20. Both courses will be conducted at the Knickerbocker Hotel in Chicago.

Each course carries 32½ hours of credit approved by the Academy of General Practice.

An outstanding faculty has been obtained for both courses, and is composed of authorities from the Chicago medical schools and other outstanding medical centers. Registration for each course is $150. Complete details may be obtained from: Chicago Medical Society, 310 South Michigan, Chicago, Ill. 60604.

Postgraduate Courses Listed By Cleveland Clinic Foundation

The 1970-71 postgraduate schedule of the Cleveland Clinic Foundation will include the following courses:

Medical Technology
October 2, 1970

Continued

FUTURES

Continued

Diagnostic Procedures in Gastroenterology
November 11 and 12, 1970

Ocular Surgery, Glaucoma and External Disease
December 9 and 10, 1970

Fifty Years of Surgical Progress
January 13 and 14, 1971

Orthopaedic Challenges - Reconstructive and Post Traumatic
January 20 and 21, 1971

New Developments in Special Procedures, Complications and Legal Implications in Radiology
January 27 and 28, 1971

General Practice
February 3 and 4, 1971

Disorders of the Red Cell
February 10 and 11, 1971

A Review of the Connective Tissue Diseases by Systems: Manifestations and Management
February 24 and 25, 1971

Update 1971 - Selected Topics in Nursing
March 3 and 4, 1971

Advances in Urology
March 10 and 11, 1971

Blood Banking
March 17 and 18, 1971

Medical Progress and Its Relationship to Dentistry
March 24 and 25, 1971

Updating Neurology
March 31 and April 1, 1971

Second Annual Cleveland Clinic Sports Medicine Symposium
April 5 and 6, 1971

Symposium in Anesthesiology
April 14 and 15, 1971

Practical Dermatology
May 12 and 13, 1971

Contact Lens Symposium
May 19 and 20, 1971

Postgraduate Course in Dietetics
June 10 and 11, 1971

Further information and programs may be obtained by writing to the Director of Education, The Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland 44106. ◄

"Horizons Unlimited" Shown to 3,000,000

Less than a year old, "Horizons Unlimited," the AMA motion picture on careers in medicine and allied fields, has already been viewed by more than 3,000,000 students. The 28-minute film has had more than 8,500 showings, of which approximately 7,400 were arranged by Modern Talking Pictures, Inc., for schools and other non-medical audiences. Since the company began distribution in the fall of 1968, the film has consistently been the second most popular of the hundreds of films stocked by Modern, the world's largest commercial distributor.

Because of the heavy demand, the AMA has increased its own Film Library prints to 44, which services physician-requests. Modern Talking Pictures stocks 220 prints to serve schools, community groups, career councils and others in recruitment activities.

I love my family.
I adore this house.
My in-laws are great.
The neighbors are wonderful.



Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack]. Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

The young homemaker: her underlying anxiety and tension can surface and intensify under the continuous stress of rearing a growing family. Especially when she's confined to the home and its environs so much.

You can help her over the rough spots with reassurance and counsel. Equanil can help relieve tension, ease anxiety—with little risk of serious side effects. Time and experience will probably do the rest.

Equanil®
(meprobamate)

Wyeth Laboratories
Philadelphia, Pa.

Photo professionally posed.



Deaths

Norval C. Folkening, M.D.

Dr. Norval C. Folkening, 57-year-old Indianapolis general practitioner, died June 27 at Methodist Hospital.

Graduated from the I.U. School of Medicine in 1936, Dr. Folkening served with the United States Public Health Service during World War II. He was on the staffs of the Methodist, Community and St. Vincent's hospitals in Indianapolis and St. Francis Hospital in Beech Grove. Dr. Folkening was a member of the Marion County Medical Society.

Naf H. Gladstone, M.D.

Dr. Naf H. Gladstone, Fort Wayne physician since 1935, died July 7 at his home. He was 60 years old.

A native of Fort Wayne, Dr. Gladstone was graduated from the I.U. School of Medicine in 1933. He served his internship and surgical residency at Marion County General Hospital, Indianapolis, then opened his office in Fort Wayne. A former president of the Fort Wayne Medical Society, Dr. Gladstone was named "Man of the Year 1960" by the Brotherhood of the Temple Achduth Vesholom of Fort Wayne. He also served on several ISMA committees and commissions.

Elbie V. Herendeen, M.D.

Dr. E. V. Herendeen, Rochester physician and surgeon, died Aug. 3 in his office at the age of 68.

Graduated from the I.U. School of Medicine in 1933, Dr. Herendeen went to Rochester in 1938 to begin his practice of medicine. During World War II, Dr. Herendeen served as a major with the medical corps of the Army Air Force. He was a past secretary and president of the Fulton County Medical Society.

Archie V. Hines, M.D.

Dr. Archie V. Hines, 78, died July 6 at the Auburn Country Club.

A member of the ISMA 50-Year Club and a Senior Member of ISMA, Dr. Hines was graduated from the I.U. School of Medicine in 1912, at the age of 20, and had practiced in Auburn since then. He was a native of DeKalb County and member of the DeKalb County Medical Society.

Frank P. Hunter, M.D.

Dr. Frank P. Hunter, a Williamsport native, died June 21 at Home Hospital, Lafayette. He was 81.

The first licensed pathologist in Indiana, Dr. Hunter had practiced pathology for over 50 years following his graduation from the University of Michigan School of Medicine in 1915. He was a veteran of World War I and served with the Army Medical Corps in France. Dr. Hunter was a senior Member of ISMA, member of the 50-Year Club and the Tippecanoe County Medical Society.

Joseph R. Karlick, M.D.

Dr. Joseph R. Karlick, 56, long-time Hamilton County physician, died Aug. 1 at his home in Arcadia.

A former president of the Hamilton County Medical Society, Dr. Karlick was a member of the medical staff of Riverview Hospital at Noblesville.

Joseph Littell, M.D.

Dr. Joseph Littell, former Indianapolis ear, nose and throat specialist, died the latter part of July at Santa Rosa, Calif. He was 75.

Dr. Littell, born in Indianapolis, had practiced nearly 20 years at Santa Rosa. He was graduated from the I.U. School of Medicine in 1918 and was a pioneer in sinus surgery in Indianapolis. He was an early exponent of plastic surgery for reconstruction of the ear, nose, face and neck. He volunteered his services at various penal, corrective and psychiatric institutions in Indiana, correcting deformities. Dr. Littell was a former member of the Marion County Medical Society.

Harvey L. Murdock, M.D.

Dr. Harvey L. Murdock, former president of the St. Joseph's Hospital staff at Fort Wayne, died July 6 at the age of 78.

A native of Huntington County, Dr. Murdock was graduated from the I.U. School of Medicine in 1921 and served his internship at the Marion County General Hospital, Indianapolis. When he moved to Fort Wayne, he served as a staff member of St. Joseph's Hospital many years and also was a resident physician at Irene Byron Hospital before 1942. He was appointed deputy health officer of the Board of Public Health in 1936. A Senior Member of ISMA, Dr. Murdock was a member of the Fort Wayne Medical Society.

Harold J. Norton, M.D.

Dr. Harold J. Norton, 71, Columbus physician, died Aug. 2 at Bartholomew County Hospital.

A specialist in psychiatry and neurology, Dr. Norton was graduated from the University of Cincinnati Medical School in 1924 and did postgraduate work in psychiatry at the Menninger Clinic. He was a veteran of the first world War and served as captain in the second world war. Dr. Norton was a member of the Bartholomew-Brown County Medical Society.

Otto F. Rogers, Jr., M.D.

Dr. Otto F. Rogers, Jr., 65-year-old Bloomington general practitioner, died July 24 in the Bloomington Hospital.

A native of Bloomington, Dr. Rogers was graduated from the I.U. School of Medicine in 1929. He had been a practicing physician at Bloomington for the past 35 years and was a member of the Owen-Monroe County Medical Society.

Dudley L. Rossiter, M.D.

Dr. Dudley L. Rossiter, longtime Fort Wayne physician and surgeon, died July 11. He was 74.

Graduated from the Northwestern University School of Medicine in 1920, Dr. Rossiter went to Fort Wayne in 1921. He served on the staff of Lutheran Hospital, of which he was a past president, as well as on the staffs of Parkview Memorial Hospital and St. Joseph's Hospital. Dr. Rossiter was a Senior Member of ISMA and a member of the Fort Wayne Medical Society.

Charles L. Viney, M.D.

Dr. Charles L. Viney, Logansport general practitioner, died there April 24 at the age of 68.

Dr. Viney was graduated from the I.U. School of Medicine in 1925 and was on the staffs of Memorial, St. Joseph's and Logansport State hospitals. He was a member of the Cass County Medical Society. ◄

Menrium® treats the menopausal symptoms that bother him most.



Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

His wife has a lot of different menopausal symptoms, but only a few really irritate *him*. Her hot flashes, her vertigo, her palpitations—that's *her* problem. What really bothers him is her nervousness, her irritability and her excessive anxiety, often expressed by endless "book-shuffling, chain-smoking, reading-lamp" insomnia!

Menrium takes care of hot flashes, vertigo, palpitations in most menopausal women. Menrium provides the well-known antianxiety action of chlordiazepoxide (Librium®) and water-soluble esterified estrogens. It therefore relieves more symptoms than either component separately. It takes care of the vasomotor symptoms as well as the emotional symptoms. This means the symptoms that bother his wife most. And the symptoms that irritate him most.

So, to help them both get through *her* menopause, remember Menrium.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

Menrium® T.I.D.

5 mg chlordiazepoxide	5-2	0.2 mg water-soluble esterified estrogens
5 mg chlordiazepoxide	5-4	0.4 mg water-soluble esterified estrogens
10 mg chlordiazepoxide	10-4	0.4 mg water-soluble esterified estrogens

Association News

BOARD OF TRUSTEES

The Board of Trustees of the Indiana State Medical Association met Saturday night, June 13th, in the Headquarters Building. The meeting was called to order by Peter R. Petrich, chairman, and roll call showed the following:

District	Trustee	
1	Gilbert M. Wilhelmus	Present
2	Joe Dukes	Present
3	Donald M. Kerr	Present
	Eli Goodman, trustee-elect	Present
4	Robert M. Reid	Present
5	Wilbert McIntosh	Absent
6	Stephen D. Smith	Present
7	James H. Gosman	Present
	Dwight W. Schuster	Present
8	Richard G. Ingram	Absent
9	Peter R. Petrich	Present
10	Vincent J. Santare	Present
11	Lowell J. Hillis	Absent
12	William R. Clark	Present
13	Otis R. Bowen	Absent

District	Alternate	
1	Eugene W. Austin	Absent
	Raymond L. Newnum, alternate-elect	Absent
2	Betty Dukes	Present
3	E. L. Wallace	Absent
4	Jack E. Shields	Present
5	C. M. Schauwecker	Present
6	Paul M. Inlow	Absent
7	John O. Butler	Present
	Joseph C. Kerlin	Absent
8	Paul W. Sparks	Absent
	Robert P. Williams, alternate-elect	Present
9	Lindley H. Wagner	Absent
10	Thomas C. Tyrrell	Present
11	James A. Harshman	Present
12	Frederic L. Schoen	Absent
13	G. Beach Gattman	Present

Officers:

Lowell H. Steen, president	Present
Malcolm O. Scamahorn, president-elect	Present
Lester H. Hoyt, treasurer	Present
Hugh K. Thatcher, Jr., assistant treasurer	Present
Frank B. Ramsey, editor, *The Journal*	Present

Executive Committee:

Donald M. Kerr, chairman	Present
Burton F. Kintner, member	Present

Delegates and Alternate Delegates to AMA:

Don E. Wood	Absent
Eugene F. Senseny	Absent
Frank H. Green	Absent
John S. Farquhar, Jr.	Absent
Jack E. Shields	Present
James A. Harshman	Present
Eugene S. Rifner	Absent
Kenneth O. Neumann	Present
Patrick J. V. Corcoran	Absent
Thomas C. Tyrrell	Present

Staff:

Robert J. Amick, field secretary	Present
Howard Grindstaff, field secretary	Present
John L. Walters, field secretary	Present
Kenneth W. Bush, administrative assistant	Present
Jas. A. Waggener, executive secretary	Present

CHAIRMAN: Members of the LaGrange County Medical Society were invited to attend this meeting but I note from the roll call that no representatives are present. I would hope that someone will be here to represent their society during our Sunday session.

Minutes of meeting of April approved.

The chair recognizes Dr. Wilhelmus.

DR. WILHELMUS: I would move that the Indiana State Medical Association not sponsor travel tours and get involved with the travel business but that counties be allowed to sponsor such trips and make it clear that all members of the ISMA are invited to participate.

The motion was seconded by Drs. Gosman and Clark.

CHAIRMAN: We have a motion on the floor, all those in favor say "aye" and those opposed, same sign. **The motion was carried by a show of hands.**

CHAIRMAN: I now recognize Judge Hamill to report on the status of our suit.

JUDGE HAMILL: I am pleased to advise you that we have reached an agreement with Blue Cross down to the very last word. The first of next week we will go before the judge of the Circuit Court at Danville, Indiana, and get the judgment entered. The essence of this will be a finding by the court that it is illegal for Blue Cross to provide professional medical services, and as a part of the judgment they also agree that all of their policies will be phased out within the next six months which carried that provision.

CHAIRMAN: We will now proceed to reports of the districts. District 1, Doctor Wilhelmus.

Reports of Trustees

DR. WILHELMUS: I would like to report that we had a little over 160 at our district meeting. For the report on the elections, Dr. George Willison has served his two terms on the Blue Shield Board and we elected Dr. Willard T. Barnhart in his place and Dr. Raymond L. Newnum was elected alternate trustee.

CHAIRMAN: Dr. Dukes, 2nd District.

DR. DUKES: There were no elections. We had a good meeting with a good turnout.

CHAIRMAN: Dr. Kerr, 3rd District.

DR. KERR: The 3rd District meeting was held in New Albany at the Robert E. Lee Motel and Dr. Eli Goodman was elected as my successor and trustee for the district. Dr. Goodman is present and I will ask him to stand and be introduced.

CHAIRMAN: The 4th District, Dr. Robert Reid.

DR. REID: Our meeting was held in Greensburg, Indiana, at which time the district increased their dues to $10.00 As far as elections were concerned, Dr. Jack Shields was re-elected alternate trustee.

CHAIRMAN: 5th District—Dr. McIntosh is not present. Dr. Schauwecker, do you have a report?

DR. SCHAUWECKER: We met May 20th in Greencastle with a fair turnout and an excellent program. The district elected William G. Bannon president for the coming year and Dr. Joe Cristee as secretary-treasurer. One item of business which might be of interest is that we are thinking about having a full time secretary for the district society.

CHAIRMAN: 6th District, Dr. Smith.

DR. SMITH: We met in New Castle at the Westwood Country Club and I was re-elected trustee and Dr. Paul Inlow of Shelbyville was elected alternate trustee.

CHAIRMAN: 7th District, Dr. Gosman.

DR. GOSMAN: There is no report of change in dues structure at this time. I will let Dr. Schuster report on the district meeting.

DR. SCHUSTER: The district meeting was held at the Ulen Country Club in Lebanon on June 10th with a good turnout. The only election was that Dr. John Records was elected president-elect.

DR. GOSMAN: We do have another matter which I thought had been reported previously that Dr. Edward J. Berman had discontinued practice and Dr. Sabra Calland will not be practicing medicine in 1970. I move that the dues of these two be remitted. **The motion was seconded by Dr. Wilhelmus, put to vote and carried.**

CHAIRMAN: I note that Dr. Robert D. Williams, the alternate trustee-elect of the 8th district is present. Could you make a report to the Board at this time?

DR. WILLIAMS: Approximately 30 attended our meeting of the district and Dr. Donald Taylor was elected as our Blue Shield Board member from the district.

CHAIRMAN: The 9th district meeting

was well attended and Dr. William Sholty of Lafayette was elected as trustee to succeed me in October.

CHAIRMAN: 10th District, Dr. Santare.

DR. SANTARE: The 10th district meeting was held at Phil Smidts on May 13th and we had a talk on oceanography. The Lake County Society has voted to increase their dues and they have hired an assistant executive secretary.

CHAIRMAN: In the absence of Dr. Hillis, can Dr. Harshman report for the 11th district?

DR. HARSHMAN: The 11th district will have their meeting on September 23 and I believe Wabash County is the host.

CHAIRMAN: 12th District, Dr. Clark. I would announce that Bill was elected as trustee to succeed himself.

DR. CLARK: I might just add that we did have a meeting and I am sorry all of you were not able to attend. We elected George Manning as district president, Frank Bryan as vice-president and William B. Hughes, secretary-treasurer.

CHAIRMAN: Dr. Gattman do you have a report from the 13th district?

DR. GATTMAN: I think our meeting has been changed from the third Wednesday in September to September 3 and we will meet in Elkhart.

CHAIRMAN: I recognize Dr. Kerr.

DR. KERR: This is a message which has just reached me and it is relative to a report from the 3rd district from the Scott County Medical Society requesting that Dr. Floyd Napper's and Dr. Thomas Hill's dues be remitted and I so move.

The motion was discussed and a motion to table for additional information and investigation was made, put to vote and carried.

CHAIRMAN: Before proceeding, I would like to remind you that all trustee reports are due in the headquarters office by July 13th. It is important that each trustee report so that it may be included in *The Journal* and in the delegates' handbook.

The next item I would like to have before we get to the reports of officers is the report on the installation of a kitchen in the ISMA building. This is a report from Mrs. Schuster who is chairman of the auxiliary committee to assist the ISMA on the kitchen project. Her report reads as follows: (At your meeting in Florida, at which time she appeared and presented plans and costs) it was requested that she compile some information concerning needs for proposed projected uses for a kitchen before it could be installed. She was informed that some of the trustees would like information on the possibility of installation of a large steam table, electronic oven, dishwasher, large grill, in general —a larger kitchen.

The question now seems to be (1) do we want a kitchen and do we think it would be advantageous to ISMA as well as the auxiliary; (2) Do we want a kitchen, small with limited facilities on a budget of about $3,000; or (3) do we want a larger kitchen with more appliances and facilities based on a budget of about $5.000? Now these three are the items on which we must make a decision so that Mrs. Schuster may make further investigation relative to cost of materials so that she may report to us later.

DR. KERR: **I would move that we have a $5,000 kitchen. Seconded by Dr. Clark.**

The matter was discussed by Drs. Clark, Kerr, Petrich and Steen.

CHAIRMAN: If there is no further discussion, I will call for a vote on the motion. The motion was put to vote and roll call was requested. Roll call showed the trustees voting as follows: Wilhelmus—nay; Dukes—nay; Kerr—aye; Reid—aye; Schauwecker—nay; Smith—aye; Gosman —nay; Petrich—aye; Schuster—aye; Santare—nay; Harshman—nay; Clark—aye; Gattman—nay; Steen—nay; Scamahorn —aye and Hoyt not voting. **The result— 8 nays and 7 ayes, one abstaining and the motion was defeated.**

DR. SCHUSTER: I would move that the Board come to a decision about the primary question, whether or not this Board wants to have a kitchen. **The motion was seconded by Dr. Kerr.**

The motion was discussed by Drs. Dukes, Gosman, and Harshman.

DR. HARSHMAN: **I would like to second Dr. Schuster's motion and amend it that we have a $3,000 kitchen.**

The motion to amend was seconded by Dr. Smith and further discussed by several.

DR. SANTARE: The motion is now an amendment for a $3,000 kitchen?

CHAIRMAN: You are correct.

DR. GOSMAN: **I move that the motion be tabled.**

CHAIRMAN: The motion to table takes precedence, I will call for the vote. All in favor aye—opposed? The motion to table fails. Now we are back to the amendment relative to a $3,000 kitchen. The motion was again made to table. The motion to table has precedence and I will call for the vote. A count of the show of hands shows the motion to table fails. We are back to the amendment on the $3,000 kitchen.

This was further discussed by Dr. Clark and others. **The motion to amend that we have a $3,000 kitchen was put to vote and the motion was lost.**

CHAIRMAN: We will now vote on the original motion which says that we will have a kitchen. All those in favor, show your hands. All those opposed, same sign. **The motion is opposed by a vote of 8—6, therefore, the motion loses.**

CHAIRMAN: We will now proceed to Reports of Officers.

Reports of Officers

DR. STEEN: I want to talk to you about something that has incited and stimulated a tremendous amount of interest on the part of the membership and about which I have had a number of personal phone calls, communications from county societies and official letters registering favorable response and unfavorable response— namely, the Himler Report. This report will come before you tomorrow for discussion and consideration as to what position our delegation should take at the AMA meeting next week.

You will remember that due to the presence of our past-president, Dr. Rifner, on the Himler Committee, we were privileged to a hearing on this report before it had been published. This Board was provided with copies of the report and you were all requested to submit opinions concerning its contents. Some of you did and some of you did not. We, as a state association, have had an opportunity to review this report for several years.

As you know, it will be voted upon at the AMA next week. The whole crux of this matter is that it is a very controversial document. People tend to polarize around this document, not in a neutral fashion, but either very positively or very negatively. I think we are at the point where polarization at the two opposite poles is extremely undesirable.

I do not think the Himler report is either good or totally bad. I think there are some elements of truth in it. I think the dissatisfaction with the report does not solve the problem as we see it relating to the AMA today and I am not sure that anyone could write a report which would unite all the forces which are represented in the AMA in a manner to suit everyone. I believe this is one of the times that we should salvage the best parts of the Himler Report without having it either categorically rejected or accepted in total.

I want to present to you a thought I had about a way of salvaging the good and putting the bad through the mill. It depends upon who looks at it whether it is good or bad without having precipitated action that will cause wholesale defections. I would like to have you consider overnight this report so that to-

morrow we can talk to the delegates concerning the potential of supporting a resolution in which the Himler Report would be referred to a committee, perhaps of nine individuals appointed by the House on a rotational basis. This committee would continuously study and independently make recommendations to the House about critical matters involving the AMA as they see it. These individuals should be members of the House, selected by the House, responsible to the House and totally free of any pressures from the administration, staff, or from the Board of Trustees. I should like to see the Board of Trustees represented on this committee with a member of the Board being selected by the House. This is a suggestion and there may be others infinitely better than this that may come from this Board. I would ask that you think about it and be prepared to instruct our delegates tomorrow so that they may vote intelligently and represent the viewpoint of the members of ISMA, bearing in mind that it is sharply polarized in two directions.

Secondly, I would like to share with you a report sent to me concerning a meeting of the National Blue Shield people with Governor Rockefeller of New York's Planning and Programming Division. This committee was composed of 100 participants and they came up with the following recommendations to improve the nation's health care. I do not present this to you for action but for your consideration and I ask that this be introduced into the minutes for further review or, at the wisdom of this chair, be referred to an appropriate board committee or to the appropriate commission of this association, probably the Planning Commission, to give it due consideration.

Their recommendations are as follows:

1. It's possible the word "crisis" is used too freely; however, there are serious problems concerning the financing and delivery of health care that need correcting.

2. Blue Shield treats doctors as sacred cows.

3. There is a need for restructuring the entire health care industry; however, only further study will tell whether this restructuring should be evolutionary or revolutionary.

4. Doctors should be consulted "to give their side of the story."

5. The next meeting should include only businessmen and no technical experts such as the ones who gave background papers.

6. We must avoid oversimplistic solutions to complex problems, e.g., have Swedes been healthier than Americans for generations or was it National Health Insurance that made them healthier—or are they really healthier?

7. We must be very careful not to get people's hopes up by promising them more than is possible and financially feasible to deliver.

8. There should be a humanly minimum level of health care benefits for everyone in the U.S. (Kaiser benefits were recommended). That should be the goal. How best to get there, we'll work out later.

9. There were numerous references to the Sidney Garfield (Director, Kaiser Plan) article in April *Scientfic American* in which Garfield says, "National Health Insurance, an attractive idea to many Americans, can only make things worse" . . . and "prepaid group practice is a step in the right direction but it is far from being the entire answer."

10. Strong sentiment was expressed in favor of a free enterprise, pluralistic competitive system in preference to a monolithic government structure.

11. Third-party insurers were not effective in making changes clearly called for, such as offering more diagnostic and preventive coverages and lower cost services such as home health visits and payment for paramedical personnel.

12. Growth of prepaid group practice is desirable and should be encouraged with federal money as the administration is now doing in Part "C" of Medicare.

13. Fee-for-service is the core of the entire problem. It results in over-utilization, unnecessary surgery, etc. There is a need for an alternative method to compete with fee-for-service.

14. Doctors are too poorly organized and self-interested to make change.

15. The group reported that they were not "swept off their feet about rushing into national health insurance the day after tomorrow." They weren't opposed to NHI philosophically but the problems of social security. Medicaid and Medicare make them skeptical of NHI. The time may come for it but we've a job to do first. Take programs already on the books and make them work by applying good management techniques. Let the competitive process decide how the job can be done best—then back that.

CHAIRMAN: We will accept the report of the president since his report is informational. We will hear next from president-elect Scamahorn.

DR. SCAMAHORN: As I approach the presidency of the state medical association, I am spending more and more time reading and thinking about the physician's role in the so-called "crisis" of medical care. Despite the forty-plus hour work week for the average physicians of Indiana, while labor seeks even a shorter work week, and most people are spending more and more time in recreation, we physicians, I believe, should become more involved with the health problems.

We are here to study, among other things, the proposed AMA action and especially the Himler Report, but more specifically, ISMA's response to this. Whatever your personal views may be regarding our current medical predicament, everyone agrees that physicians are suffering in an atmosphere of acute problems. In my opinion, only through a medical organization such as the ISMA or AMA can we individually or collectively be heard. We are a minority group that must be heard and we must prepare ourselves to participate in a way in which to influence decisions.

Opportunities are constantly present—locally, statewide and nationally—for us to be heard and for us to provide leadership. Physicians generally, not just those of us here tonight, must become more involved. This health care problem is more profound and ominous than many physicians realize. Most M.D.'s in Indiana go about their busy practice expecting ISMA leaders to solve this big problem for them. It is a quantitative and a qualitative problem with social, economic and psychological elements.

I believe that the public generally feels that medicine has broken its sacred trust and that we as physicians are falling way short of delivering the type of health care at the quality that should be available in America today. This, to me, gentlemen, is ours to challenge. The Himler Report to me represents a crying awareness of our profession to meet this challenge which I have mentioned. Let us share our own philosophy, our own thoughts, and our prejudices in private and then agree to bury them for the duration of this crisis or this problem.

CHAIRMAN: We will now proceed to the report of the treasurer.

DR. HOYT: The treasurer gave a report on the fund balances, expenditures and the investment portfolio as of the end of May and moved that this report be adopted; seconded by Dr. Wilhelmus. **The report was discussed by several, put to vote and adopted.**

CHAIRMAN: We will now call on Editor Ramsey.

DR. RAMSEY: I have no report at this time.

CHAIRMAN: A Committee on Memorials has been appointed, composed of Dr. Ralph Everly, Dr. Maurice Glock and Dr. Joe Dukes.

Reports of Committees

CHAIRMAN: We will next go to the reports of Board committees and I will

make the report on the Board Committee on Medical Education and Liaison with the I.U. School of Medicine. There is a pilot program in physicians' assistants in process through the Regenstrief Foundation. The proposal that the state medical association and the university get together very quickly and decide about a possible proposal for expanding any program has gotten nowhere. I still have not had a response to a letter written many weeks ago concerning this.

CHAIRMAN: Dr. Santare will give a report on the Liaison Committee with Blue Cross.

DR SANTARE: Blue Cross has obliged by inviting Dr. Harshman and me to their meetings; Jim has attended all the meetings and I have missed three due to weather and other causes. The points that have come up in the Blue Cross meetings which I think are of interest to us are: (1) This committee was asked to investigate the possibility of outpatient diagnostic procedures being paid for by Blue Cross in doctors' offices in lieu of the present arrangement in which they only allow payment for outpatient procedures done in the hospital. Blue Cross will not pay for this physician service but the answer is that we must get an arrangement with Blue Shield to provide this service. The Medical Advisory Committee has arranged, through the efforts of Dr. Harshman, Dr. Neumann and Dr. Rifner, that the Executive Committee of Blue Cross and Blue Shield will hold a meeting next week at which time this matter will be discussed.

(2) The next point was the irritation of some of our members concerning the fact that Blue Cross field men were presenting themselves in hospital staff rooms and talking to doctors about Blue Cross. At the instigation of Dr. Harshman, we won't be bothered with Blue Cross field men bothering us about Blue Cross questions in the hospitals in the future.

(3) The third point was the one concerning extended care facilities under Medicare. This was discussed at length and I can read minutes here about three or four paragraphs on it, and actually they don't come out with any solution. The proposal of Dr. Jones would be that a physician, a nurse, or a social worker find out about the extended care facilities and nursing facilities before the patient is transferred to determine their eligibility and notify the patient or the doctor. This does not answer the problem, it merely alleviates the difficulty of the patient being transferred only to find out they are ineligible for coverage. We do not have an answer to it. I don't think Blue Cross has one either. This is a question where utilization committees should get the patient out of the hospital. We get the patient out; we send the patient to an extended care facility and after the patient has been there for sometime he is told he is not eligible for benefits. Maybe Dr. Harshman would like to comment.

DR. HARSHMAN: I come to the point that was brought up by Dr. Neumann and I am sure we all face the same problem, that is the problem of emergency rooms whereby the hospitals are now hiring full-time physicians to handle emergency room cases. These people are taken out of private practice to handle the itinerants in the hospital. Neither Blue Cross or Blue Shield will pay for house calls or office visits yet they pay the emergency room physician $15.00 to $20.00, whatever the price may be. They will pay the hospital for the use of the emergency rooms which varies according to the service rendered, but nothing less than $10.00 to $15.00 and in some areas they are also paying for the ambulance expense of taking the patient to the emergency rooms. When the whole bill is added up, the Blues are getting bills of $40, $50, $60, for a visit which could have been taken care of by an office visit or a house call at a far less cost. This is a problem I think is extremely critical at the present time.

In Lafayette, for example, they have nine physicians covering two hospitals, and in Kokomo we have possibly nine physicians covering two hospitals. We are finding that the hospitals are hiring physicians to man emergency rooms and taking these people out of private practice and this is causing quite a problem all over the state. It would appear that this will bankrupt the Blues if they continue to pay these exorbitant bills for use of emergency room treatment.

CHAIRMAN: Dr. Santare, I am wondering if you have had any opportunity to investigate the cost for the physicians' insurance program. Remember our discussion concerning coverage by Blue Cross-Blue Shield, and the increase in rates, and whether or not we were able to get a relative cost from other companies.

DR. SANTARE: The experience I have had with Equitable, Connecticut, and John Hancock is that they will be much more expensive than the Blue Cross-Blue Shield Plan which we have. They cannot compete with it and cry when they see it. Dr. Santare moved to accept the report. **The motion was seconded by several, put to vote and carried.**

CHAIRMAN: We will now move on to the Board Committee with Blue Shield.

DR. DUKES: I have distributed to the Board the recommendations made by Dr. Neumann to Blue Shield concerning certain changes to be made in the material now sent to patients and doctors. I would move that these be officially adopted by this Board. **The motion was duly seconded, put to vote and carried.**

DR. DUKES: Blue Shield, as I see it, is really operating in three areas as of now. There is a Blue Shield Plan with the ordinary business, as was started in 1946 and has worked very well throughout these years. Then came Medicare and Blue Shield was involved in the administration of this program. Medicare, as far as I can see, is a program with which we can live because we have the alternative of either accepting or rejecting assignments under the program. The doctor cannot really be tied down.

Then we get to Medicaid, which is another horse, and if you hear as many complaints as I do on Medicaid, I have yet to find anybody happy with it. I think we ought to think what we could do or recommend. I am not sure we should not recommend that Blue Shield disassociate themselves as a carrier for the Medicaid program. I think there are a lot of doctors who believe that Blue Shield is just a straight insurance company and that maybe the doctors should stay out of it but we have a $40,000,000 corporation down there and there are a lot of people who would like to have it. I think we ought to keep our fingers in it if we can and live with it.

CHAIRMAN: Is there any discussion?

DR. GOSMAN: Only to agree with what he has said. I think we should stay in it and battle it out with Blue Shield the best we can.

The motion was further discussed by Dr. Butler, Dr. Dukes, Dr. Schuster, Dr. Wilhelmus, Dr. Kerr, Dr. Steen and Dr. Santare. **Dr. Dukes moved the acceptance of his report, seconded by Dr. Gosman, put to vote and carried.**

CHAIRMAN: We will next move to the Board Committee on Economic and Fiscal Matters, Dr. Wilhelmus.

DR. WILHELMUS: The committee met this afternoon for over three hours with Mr. Nyhart and his associates who handle our company retirement plan. We have an excellent retirement plan for our employees but thought it should be brought up-to-date and modernized to conform with some of the new federal regulations concerning retirement programs. At this time I would like to move that we change the retirement plan to meet the regulations.

The motion was seconded by Dr. Steen, put to vote and carried.

DR. WILHELMUS: This motion was made because we are forced by federal regulations to change our plan. I would like to discuss this a little bit more as it is a complicated procedure. I discussed this with my own insurance agent and with the Nyhart people this afternoon, and at the

present time I think we should let the employees assist us to determine what is best for the retirement program. At the present time, the retirement program is based on annuity policies and when salary increases are given we buy additional annuity insurance to cover the program. As a result, we have a stack of insurance policies and he is suggesting that we take the cash values of these policies and place them in a trust account. The committee is still working on this matter and hope within the near future to come up with a final idea which we can then recommend to this Board for adoption.

The next item given to this committee was to come up with some prerogative on donations to charitable organizations. We came up with three items which we feel at the present time must be met for an organization to receive a donation from this association: (1) They must benefit the physicians over the entire state; (2) It must be related to the medical field; (3) They put this in sort of a catch-all in the hope that the executive committee will not abuse it—any activtity that brings worthwhile public relations to the ISMA. Mr. Chairman, I move we adopt these priorities as a basis for ISMA charitable donations. **The motion was seconded by several, put to vote and carried.**

DR. WILHELMUS: We are also charged with the responsibility of reviewing the financial position of the association. You all have a copy of the breakdown showing where every penny of the $90 you pay in dues is spent. This is based on ¾ of the current fiscal year. At the present time our expenditures will run $102.03 on a $90.00 income, so we are spending more than we are taking in. It would appear that we are going to have to cut down on expenses or raise the dues. You will note that we are currently putting money in the building fund reserve and I wonder if this should be transferred to the general operating fund. I would therefore move that we consider this transfer of funds.

DR. KERR: I would move that this be discussed with our accountants. **The motion was seconded by Dr. Steen. The motion was discussed by Dr. Wilhelmus, Dr. Kerr, Dr. Dukes and Dr. Schuster.**

DR. STEEN: **I move that we refer this matter back to the committee, seconded by many, put to vote and carried.**

CHAIRMAN: Dr. Wilhelmus has a continuation of his report—and are you prepared at the present time to follow the edict of the 1969 House of Delegates and report to the Board as to whether or not you feel that the status of the association financially requires a raise or reduction in dues for the calendar year 1970-71?

DR. WILHELMUS: I believe the treasurer and accountants should come up with the really final say. I can see we are going in the red and I do not see how we can keep out of raising the dues.

CHAIRMAN: I will take this opportunity on behalf of the Board to commend this committee for accepting this job and the way they have dug into the financial affairs of the association. We will have a meeting in September and we would hope that a tangible recommendation relative to an increase or reduction of dues will be forthcoming so that the Board may act in its entirely and report its conclusion to the House of Delegates. I believe this would eliminate the criticism on the part of the delegates not having an opportunity to discuss it with their own members and I believe this would give them an opportunity to review this matter before coming to the state meeting in October.

CHAIRMAN: Dr. Ingram is absent but in a telephone conversation he says he has no additional report on the Joint Committee on Emergency Medical Services, therefore, we will move to the Board Committee on Orientation of New Members, Dr. Clark.

DR. CLARK: I have been meeting with the Special Services Commission and they are doing an excellent job. They are investigating this in about three different ways: (1) They have gone to the university to discuss with Dr. Irwin the establishment of a course in the medical school to indoctrinate medical students concerning the AMA, the state medical association, and organizations such as county medical societies, and specialties, and what they are doing; (2) Then we have another study being made about developing a system for orientation of new members by county medical societies; and (3) I believe the Orientation Committee should continue to work with these fellows and assist them in accomplishing the task they have set forth to do. In fact, we will meet with them at 10 o'clock tomorrow morning and perhaps in the afternoon we may have a formal resolution pertaining to the requirements, as now established by the Constitution and Bylaws, so we may have it for presentation to the House of Delegates in October.

CHAIRMAN: This will be fine and the Board can then take definitive action and refer their recommendation to the Commission on Constitution and Bylaws for a change concerning the mandatory provision as it now stands.

DR. REID reported on progress to date of Ad Hoc Committee on computers.

I have had the opportunity to view the computerized instruction program at Ohio State University which, I think, if you had an opportunity, you would find extremely interesting. We are rapidly moving toward this field for instruction purposes and maybe a program which could be sponsored by the ISMA. This could be expanded into patient areas and in many other types of application. I believe the public relations value would be great if the ISMA is beginning to think a little bit about developing these kind of programs for physicians and other appropriate organizations.

The report was discussed by several and on motion duly made and seconded, the report was adopted as presented.

CHAIRMAN: We will move on to the report of the Joint Committee on Education, Dr. Gosman.

DR. GOSMAN: We met for four hours this afternoon and six members of our committee were present. The first order of discussion was the Peer Review Committee. It is our recommendation that every effort be made to establish a Peer Review Committee which will function in an educational way rather than just a review manner. We therefore recommend to the Board that a State Committee of Peer Review be formed to provide guidelines to a County Peer Review Committee. We further recommend that this State Peer Review Committee be established to handle problems sent to it from County Peer Review Committees—that is, problems which they feel are beyond their power to adjudicate, and finally, we recommend that the composition of the Peer Review Committee consist of members from every section that are practicing medicine in the state of Indiana. We are not trying to say the total number of members of this committee but we are saying it should be composed of members from every section. On the basis of the recent survey, a great majority of physicians answered in the affirmative in favor of peer review, so my committee therefore recommends to the Board that we suggest to the House of Delegates that they come up with appropriate finances to finance the operation of a State Peer Review Committee and I so move.

CHAIRMAN: **The motion has been seconded by Dr. Kerr.** Any discussion? **The motion was put to vote and carried.** We will prepare an appropriate resolution for presentation to the House of Delegates.

DR. GOSMAN: We then discussed the plan of the Governor's Commission for a Statewide Medical Education Program. We felt the following should be appropriately presented in a resolution: (1) That it does provide at this time a stop-gap type of measure; (2) That it does not provide at this time a satisfactory program, as

perhaps would a second medical school in the state, but in considering the cost and all the other ramifications in setting up a second medical school, it does provide a means for developing larger medical school enrollment. We are not certain that it is the answer from the long-haul point of view.

We felt there was a possibility by the present way it is established that this might develop a nucleus of basic science professors and teachers whereby at a future date a second medical school might be developed. We feel that the association must strive to assist in every way possible to obtain adequate funds for the hospitals who are affiliated with this program. Under the plan, the hospitals that are engaging in this program are actually doing part of the teaching for the university and inasmuch as this takes time of the physicians and of the facilities, they should be appropriately reimbursed for this effort.

In conclusion, we suggest that the ISMA heartily support the plan at this time for the Statewide Medical Education Program and that the ISMA continue to participate in the Governor's Commission on Medical Education; I move the adoption of this portion of my report.

This was discussed by Dr. Wilhelmus, Dr. Clark and others. **The motion was duly seconded, put to vote and carried.**

DR. GOSMAN: The next subject was delivery of health care in Indiana. Our committee feels that we are now beginning to show a little dividend on more of our physicians graduating from our school going into the family type of practice. My own relationship with interns and residents would support this particular idea. We felt that we should support the development of a Chair for Family Practice at Indiana University. May I suggest that those of you who are planning on contributing to the 150th Anniversary Fund of Indiana University that you stipulate, if you so desire, that your money be used for establishment of such a Chair in this field at I.U.

Next we felt we should develop programs for some of the men who are returning from military service and those who are out in general practice who desire to return for residency training; encourage educational compensation; subsidize residency programs, so they can still serve the purpose. Our idea still is that if a group of physicians out in the city practicing together, the group type of practice, perhaps we should attempt to set up with our hospitals some sort of a training program where a man could go out with them for two weeks; four weeks; for the specialized training he desires. If he wished to return again the next month for a two week period that somehow, some way, this training could be worked out on a four month or six month basis, whatever it may be. We feel that we should push for making this type of an educational program a full-time, dynamic program.

We also have a well organized profession of nurses and we should strive to develop this group as allied medical personnel. We also feel there is a great supply of medical and surgical technicians being dismissed from the military service who could perhaps be permitted to take an exam and, if passed, register them as nurses or technicians. These people could be used out in the country as a source to which people could report for their temperature or blood pressure and with a group of physicians practicing in a neighboring community, a physician should be contacted, given the story and make a decision as to either send the patient to a hospital or inform them what to do at that particular time.

Computerized possibilities were also discussed. Dr. Reid has previously presented this idea to you. We have discussed the medical-legal aspects of these problems and we have no particular recommendation at this time on this subject. I would move, therefore, to accept this report.

CHAIRMAN: Dr. Gosman has moved the adoption of his report over and above his recommendations that have been moved, seconded and passed already. **The motion was put to vote and carried.**

Matters Referred by Executive Committee

CHAIRMAN: We will now move to matters referred to the Board by the Executive Committee, Dr. Kerr, Chairman.

DR. KERR: The Executive Committee has discussed the matter of trying to relate the matter of the field service to the Regional Medical Program. You will remember Dr. Gosman brought to this Board a year or so ago the request for approval of the Regional Medical Program. The Board did give this approval. Since that time it has been noted by some that the program has not particularly moved off center and is largely located in Marion County.

Approximately six weeks ago there were discussions between the RMP group, Dr. Steen and Mr. Waggener regarding the possibility of getting two field men, financed by RMP, to work for the state medical association and then we would have five field men working not only on association affairs but on RMP. We have a rather lengthy letter from Dr. Stonehill, who is the coordinator, and he does not support this view at all. There is a proposal which has been prepared by Mr. Waggener which has not yet been submitted to RMP, pending the approval of the Executive Committee. The letter from Dr. Stonehill seems to already negate the possibility of the association making the proposal. As a result of the discussion before the committee this afternoon, there was a proposal by Dr. Steen that the Board of Trustees recommend that the Indiana State Medical Association withdraw its support of RMP as presently organized and presently operated.

DR. REID: I so move.

The motion was discussed by Dr. Butler and Dr. Kerr.

DR. GOSMAN: I would like to suggest that we table this until after we hear from Dr. Stonehill tomorrow. I so move. **The motion to table was seconded, put to vote and carried.**

DR. KERR: The next item is a letter from the Board of Health announcing the fact that they have been assigned the responsibility by the Governor as a clearinghouse for state planning and development of grants for the purpose of reviewing applications for federal funds. They have indicated they will be reveiwing the funding in 31 various areas.

DR. KERR: The next item is a resolution of thanks from the Indiana physicians to WFBM relative to the Teen Health Happening, which reads as follows:

WHEREAS, The problems of youth are today of a priority concern to parents, school officials, government leaders, and members of a multitude of voluntary and professional associations throughout Indiana, and,

WHEREAS, the Indiana State Medical Association recognizing the need for the medical profession's participation in assisting in the educational and informational aspects of the program, organized and sponsored the "Hoosier Teen Health Happening," and,

WHEREAS, Indianapolis television station WFBM-TV, Channel 6, recognizing, equally, the value of imparting to the parents and general public information on drug abuse, smoking, sex, alcohol, traffic safety and the law, contributed a full day and a half to live color coverage of the entire event,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association extend to this station a special thanks for this coverage and their concern, which has had continuing educational impact in the Indiana school systems and youth organizations through use of films and audio tapes developed from the program.

I move the adoption of this resolution.

The motion was put to vote and adopted.

CHAIRMAN: I would like to make a recommendation that we formally propose the name of Dr. Burton E. Kintner for the AMA Committee on Medicine and Religion. **This was seconded by many and adopted.**

The meeting was then recessed to Sunday, June 14, 1970.

BOARD OF TRUSTEES

The chairman called the meeting to order at 9:30 a.m., June 14, in the Headquarters Building. Roll call showed the following:

District Trustee

1st—Gilbert M. Wilhelmus, Evansville Present
2nd—Joe Dukes, Dugger Present
3rd—Donald M. Kerr, Bedford Present
Eli Goodman, trustee-elect, Charlestown Present
4th—Robert M. Reid, Columbus Present
5th—Wilbert McIntosh, Riley Absent
6th—Stephen D. Smith, Knightstown Absent
7th—James H. Gosman, Indianapolis Absent
Dwight W. Schuster, Indianapolis Present
8th—Richard G. Ingram, Montpelier Absent
9th—Peter R. Petrich, Attica Present
10th—Vincent J. Santare, Munster Present
11th—Lowell J. Hillis, Logansport Absent
12th—William R. Clark, Fort Wayne Present
13th—Otis R. Bowen, Bremen Present

District Alternate

1st—Eugene W. Austin, Evansville Absent
Raymond L. Newnum, alternate-elect, Evansville Absent
2nd—Betty Dukes, Dugger Present
3rd—E. L. Wallace, New Albany Absent
4th—Jack E. Shields, Brownstown Present
5th—C. M. Schauwecker, Greencastle Present
6th—Paul M. Inlow, Shelbyville Absent
7th—John O. Butler, Indianapolis Absent
Joseph C. Kerlin, Danville Absent
8th—Paul W. Sparks, Winchester Absent
9th—Lindley H. Wagner, Lafayette Absent
10th—Thomas C. Tyrell, Hammond Present
11th—James A. Harshman, Kokomo Present
12th—Frederic L. Schoen, Fort Wayne Absent
13th—G. Beach Gattman, Elkhart Present

Officers:

Lowell H. Steen, Hammond, president Present
Malcolm O. Scamahorn, Pittsboro, president-elect Present
Lester H. Hoyt, Indianapolis, treasurer Present
Hugh K. Thatcher, Jr., Indianapolis, assistant treasurer Present
Frank B. Ramsey, Indianapolis, editor, *The Journal* Present

Executive Committee:

Donald M. Kerr, Bedford, chairman Present
Burton E. Kintner, Elkhart, member Absent

Delegates and Alternate Delegates to AMA:

Don E. Wood, Indianapolis Present
Eugene F. Senseny, Fort Wayne Present
Frank H. Green, Rushville Absent
John S. Farquhar, Jr., Fort Wayne Present
Jack E. Shields, Brownstown Present
James A. Harshman, Kokomo Present
Eugene S. Rifner, Van Buren Present
Kenneth O. Neumann, Lafayette Present
Patrick J. V. Corcoran, Evansville Present
Thomas C. Tyrrell, Hammond Present
Lall G. Montgomery, Muncie, delegate, AMA Section on Pathology Present
Sprague H. Gardiner, Indianapolis, alternate delegate, AMA Section on Obstetrics and Gynecology Present
Myron H. Nourse, Indianapolis, alternate delegate, AMA Section on Urology Absent

Staff:

Robert J. Amick, field secretary Present
Howard Grindstaff, field secretary Present
John L. Walters, field secretary Present
Kenneth W. Bush, administrative assistant Present
Jas. A. Waggener, executive secretary Present

Guests:

Larry Pickering, Executive Director, Fort Wayne Medical Society Absent
John B. Twyman, Executive Director, Lake County Medical Society Absent
Polly T. Dent, Executive Secretary, LaPorte County Medical Society Absent
Arthur G. Loftin, Executive Secretary, Marion County Medical Society Present
Harry C. Davis, Executive Secretary, St. Joseph County Medical Society Absent
Carole Rust, Executive Secretary, Vanderburgh County Medical Society Absent
Ray Purcell, Executive Secretary, Vigo County Medical Society Absent
Glenn W. Irwin, Jr., M.D., Dean, Indiana University School of Medicine Present
Andrew C. Offutt, M.D., Secretary, Indiana State Board of Health Present
Joe M. Black, M.D., Chairman, Blue Shield Board Present
Robert Stonehill, M.D., Coordinator, Indiana Regional Medical Program Present
Norman R. Booher, M.D., Chairman, Commission on Voluntary Health Agencies Present
Thomas J. Conway, M.D., Chairman, Commission on Medical Economics and Insurance Absent
A. Alan Fischer, M.D., Chairman, Comission on Inter-Professional Relations Absent
Jerome E. Holman, Jr., Chairman, Commission on Governmental Medical Services Present
Richard Kilborn, President, Mutual Medical Insurance, Inc. Present
Pete Foster, President, Indiana Chapter, Student AMA Present
Don Dian Present
Fred Smith, M.D. Present
Harold Ochsner, M.D. Present

Members of LaGrange County Medical Society:

Francis X. Colligan, M.D., Topeka Absent
Harley F. Flanigan, M.D., LaGrange Absent
John Hamer, M.D., LaGrange Absent
Kenneth M. Lehman, M.D., Topeka Absent
Allen S. Martin, M.D., Shipshewana Absent
Dean L. Mattox, M.D., Howe Absent
Michael O. Mellinger, M.D., LaGrange Absent
Lloyd Studebaker, M.D., LaGrange Absent
M. Reed Taylor, M.D., Howe Absent
Philip E. Yunker, M.D., Howe Absent

Chairman of the Board Dr. Peter R. Petrich, called upon the delegates and alternate delegates to the American Medical Association to individually report to the board on the many resolutions and reports from AMA committees which would be presented to the forthcoming annual convention of the AMA.

A discussion of some of these issues follows:

CHAIRMAN: Dr. Eugene Senseny, chairman of the delegation. Dr. Senseny.

DR. SENSENY: Thank you, Dr. Petrich. The original report here, A-70, of the Board of Trustees, is a financial statement. Most of this is self-evident. The real importance, I think, comes in the projected Report B of the Board of Trustees which is the AMA

dues increase. Now we have not particularly discussed this so I will share a few of my own personal opinions about this. Basically I am in sympathy and feel there is justification in the proposal for a dues increase. I think the substantiation for the dues increase is relatively clear on page 811. There is a projected 5.8% increase which is the impact of inflation, as they term it. Now I would like to state that regardless of how I personally feel, I think this would have a great impact on the members of our district. I think they will find it very difficult to accept, regardless of how substantiated this report might seem to me. I think this is one of the prime considerations for a discussion at the meeting of the AMA in Chicago and I think we had better think about this a little bit out loud.

DR. CLARK: Dr. Senseny, as I review this information I get the idea personally that we need to increase the dues and I'll go along with this. But I feel I'll have difficulty in selling the idea to the Twelfth District. All the men I've talked to, at least 25 or 30 of them, want no part of a dues increase. I can't see this big an increase. I would not like to see our delegation go to Chicago to support it. Perhaps something could be worked out relative to a gradual increase in dues.

CHAIRMAN: Thank you, Dr. Clark. Dr. Steen.

DR. Steen: They're asking for a 110% increase. And they say in 1975 they'll need seven million more than they're receiving now; and, of course, this 110% raise will bring them eleven million per year. Also, they're still spending over one million dollars on this research project. There are several things I would like to know about, including honoraria and grants totaling $1,700,000. This seems like a great deal of money to me. Could some of these meetings be cut down? They don't mention SAMA. I think they are giving up to 80 or 90 thousand dollars a year to SAMA. I think these are some of the questions that the delegates had better consider.

DR. WILHELMUS: The question arises of how much money is going down the drain from a poor business aspect—as I understand the Board of Trustees is paying three executive secretaries at the present time.

CHAIRMAN: Is it necessary for us to have a concrete proposal about our attitude?

DR. SENSENY: I would only suggest this, that I think the conversation here this morning in a sense truly speaks for itself. I think that the issue will be discussed enough. I would hope that the trustees would depend on the judgment and the wisdom of the delegates in this area to do what they think proper for the state association in this area.

CHAIRMAN: I think from the tenor of the conversation, everyone is in general agreement.

DR. SENSENY: Mr. Chairman, I'll now report on Report C. You will remember from the last meeting, the mandate of the House of Delegates to the trustees has been for them to develop some sort of answer relative to malpractice or liability insurance programming, and that is what this report details. The significant sentence in the sponsorship of liability insurance programs is that it has been concluded that the best way to provide such insurance is on a collective rather than an individual basis under programs jointly sponsored by the AMA and the respective state medical associations. The second item of some significance is the institution of remedial state legislation. The report says that it appears that the best means open to provide some restraint of trends is in such legislation. I have no other comment on Report C except to question whether or not this is the best way to approach the problem—that being for us, basically, to be involved in the insurance business.

CHAIRMAN: Dr. Neumann, would you like to report on the ISMA malpractice survey?

DR. NEUMANN: The response to the survey was most gratifying. In general, about 70% of the membership replied. Members indicated they thought the ISMA had a responsibility to assure availability of malpractice insurance to all its members; this constituted about 2/3 of the group responding, but when it came down to whether they would be willing to pay an extra premium to cover these groups, only approximately 1/3 were willing to pay the additional premium necessary to get a broad overall coverage. Only 40% were willing to change their present plan of malpractice insurance if an ISMA-sponsored program were the only way to provide such service. Another equal number said they would not, and the other half were undecided. When it came down to asking whether they would be willing to pick up an increase in premiums, it was overwhelming that they would not. One of the surprising things was an overwhelming response to approval of peer review changes in ISMA policies. However, back at the district level, the response was that they were interested in peer review only in malpractice areas and they did not interpret it as peer review over the whole gamut of medical services. The new thing that is on the horizon in malpractice is the so-called punitive damages against physicians in malpractice cases. There have been no cases to my knowledge filed in Indiana on this basis.

DR. SENSENY: Report C of the Board of Trustees asked the House of Delegates to establish a policy on abortion. To refresh your memory, in Atlantic City three years ago, the House of Delegates accepted the policy statement of the AMA on abortion, and I personally felt that it was a very reasonable thing. I think this is going to be a hot issue in Chicago and I would like to ask Dr. Sprague Gardiner if he will comment on this.

DR. GARDINER: The only reason that I am interested in this is because we did help write the original AMA policy statement. We helped write the policy statement for the Indiana OB-GYN. This came as kind of a surprise to me as chairman of the General Child Care Committee. Now, we have recommended in our resolution that we strongly urge that standards set up in hospitals regarding the performance of this procedure correspond to other types of procedures with the same rules and regulations regarding this procedure. Secondly, any physician who, for any reason at all, does not want to participate in abortions, that there be no legal or medical incrimination against him or against any consultant he might call. Thirdly, we point out that this procedure is associated with morbidity and mortality and that the further the pregnancy, the greater the risk to the patient. I think probably within a year the Supreme Court may very well rule that the laws restricting abortion are unconstitutional. I think this is a realistic statement, but I think we ought to have a lot of safeguards in there.

QUESTION: Will we have enough hospital beds to handle cases? Do you have a comment about that, Dr. Gardiner?

DR. GARDINER: It can overtax existing medical facilities. (Dr. Gardiner further elaborated on the points, stating that there weren't enough nurses to participate in such procedures and the cost would be considerably higher initially.)

DR. SENSENY: Well, I think again, Mr. Chairman, that Dr. Gardiner has pointed out what is really significant about this and that we should follow the guidelines set down by his committee. And again, I would like to suggest we go uncommitted in this area.

DR. WILHELMUS: I will make a motion, then, that we are against any change in the present abortion laws.

CHAIRMAN: **The motion is made by Dr. Wilhelmus that we retain the stand taken previously by the AMA regarding abortion. Seconded by Dr. Santare.**

DR. SANTARE: There are a number of points here that we have got to distinguish. One is the legality of the thing. I don't

think that anyone should go to jail for doing a D and C. I don't think any of us would oppose rescinding such laws which would make it criminal for a physician to do a D and C. On the other hand, here's a group of professional men who are dedicated to the preservation of life. And I see patients on the other end of the spectrum when we get them 65 and over, and we use everything in our means to keep them going. Now we know that a unified organism begins with a fertilized ovum. When does it become an individual with some rights? We don't know this. Since we in medicine are dedicated to the preservation of life and we don't know, I don't think we as an association ought to go ahead and say "turn it loose." This is the way I feel about it, personally.

DR. THATCHER: I think this is the factor that we've got to solve—mainly that there must be a medical decision; that there is a necessity. I can remember in my own instance a woman who was nearly at the breaking point as far as her mental status was concerned after having a number of previous problems, and this abortion was denied because at that time the psychiatrist felt that there might be a greater guilt complex after she had done it than in agreeing to it in the first place. And I think this is a realm on which all branches of medicine have to agree. I think this is what should be discussed before any decision is made at a national level.

DR. CLARK: I don't believe that this is going to create any more abortions than have ever been done before. I think it's going to transfer the abortions from the back room to the front. I actually believe that some of these people should have some legitimate recourse.

DR. TYRRELL: I think this problem is a little difficult. I think it becomes very simple to tell delegates to vote on economic matters but some of these things we are discussing are so deep down in this whole structure that you couldn't instruct them in 20 years how to vote on this matter regardless of whether they represent you or not. This is an entirely different stage than we have ever been at before. You talk principles and ethics of mankind and you're not going to tell anyone how to vote. This is why I think you should be careful when you instruct this delegation.

DR. SANTARE: **I have read this over again and I will withdraw the second to that motion.**

DR. WILHELMUS: **I will withdraw my motion.**

CHAIRMAN: You will now hear from Dr. Farquhar.

DR. FARQUHAR: Report L is the report of the trustees on "Citizens Commission on Graduate Medical Education." This seems to dovetail the material already given by Dr. Harshman. "After July 1, 1971, a new internship program shall be approved only when the application contains convincing evidence that the internship and the related residency years will be organized and conducted as a unified and coordinated whole.

"After July 1, 1795, no internship program will be approved which is not integrated with residency training to form a unified program of graduate medical education." This, then, takes away the internship totally, and they go on to state that programs of graduate medical education should be given only in those institutions which have adequate patient material, teaching staff, ample services to support them; that the program should be accredited to the institution and not to a service and not to an individual; and there should be a newly-created Commission on Graduate Medical Education; and that each Residency Review Committee should include a few members from outside that particular specialty. And I think this is the shape of things to come and I believe Dr. Harshman has commented on this most appropriately already.

CHAIRMAN: Dr. Irwin, would you please come forward?

DR. IRWIN: This report has profound impact upon statewide medical education system and it's very important that we get our house in order right now. From the standpoint of getting approved residency programs where approved internship programs now exist, I think we can do this all right. We cannot end with just a few residencies in Indianapolis or a few large cities. The whole concept of our statewide system has been to get the young men out to the corners of the state because we know that if we can do this, we can get individuals to remain in these localities. In the last three years, we have been able to, with this system, attract 103 more interns and residents in our state system even though the number of graduates from our school has remained essentially constant. So those of us at this school will certainly work with this organization and with those that are knowledgeable about internship residency programs to be certain that what we have already done, or what you have already done, in many of your areas, is carried on. Whether we call it an internship or residency, I don't think it makes much difference, just as long as we have the approved programs where they are now.

(The Board then discussed at great length the effect of this programming on family practice. The Board further discussed changes which had more recently taken place in the medical school curriculum and the method of training and instruction as well as the efforts being made to shorten the training of a physician.)

DR. SCAMAHORN: To sum this up, I would like to say that the Board take action to inform the delegates that we do not say "yes" or "no" particularly to this report but urge that they support the premise that the educational process be shortened and that every attempt be made whereby more primary physicians can be graduated in a shorter period and be available to the public for medical care.

Dr. Jack Shields then introduced a resolution asking that the AMA Public Relations Department devote at least 75% of its time "in getting our message to the public by utilizing the many weekly and daily newspapers as well as TV and radio in America who certainly can be influenced by physicians and local and state medical societies as well as the AMA . . . ." There was a great deal of discussion about this resolution. **Dr. Schuster moved its adoption, seconded by several and passed.**

Dr. Petrich called on Dr. Wood.

DR. WOOD: My first report is Report J of the Board of Trustees, Medicare Payments for MDs in Teaching Hospitals. The main problem here is who shall collect the fees, under Part B Medicare, in teaching institutions? I think the AAMC, as Dr. Irwin told me, has recommended that the individuals who have gone beyond the resident's training program and become fellows or instructors would then be the ones who would become eligible to sign the Medicare forms and receive payment under the program. The Board of Trustees recommends that the AMA continue to be actively involved in this matter and that the responsibility remain with the Joint Liaison Committee of the Council on Medical Service and the other committee that was appointed to work on this program.

The next is on the Himler Report: Planning and Development, including the major report and the minority report. Recommendation 5 is that an appropriate committee or division of the association secure data from all the state medical societies on the adequacy of health services, the manner in which they are being provided in their rural and underprivileged areas and the practice mechanisms and to consider developing a correction program of existing deficiencies. Based on this information, the same committee should devise delivery systems consistent with the association's principles and incentives for physi-

cians to settle in medically-deprived localities.

The next point is that the association shall establish a service of consultation and assistance for such physicians to facilitate the planning and financing of their projects. The third one is that the AMA be urged to encourage and assist the state and local medical societies to do so on an operational basis. And, four, that the association study the possibility of establishing a corporation for the purpose, with subsidiary corporations at state and local levels. These corporations should be legally empowered to receive payments for services rendered, and the constituent and component medical societies seek the active involvement of medical centers and voluntary hospitals in health service projects for the medically underprivileged.

(Dr. Wood then cited the various resolutions of several state associations asking for different actions in all of these areas which he had described and reported additionally on some of the matters pertaining to the minority report to the Himler Report. Dr. Steen reported again what he had reported to the Board of Trustees on the preceding day.)

DR. STEEN: I think one has to recognize that there is some good in this report and there are some things with which we don't agree. In a report of this length and a report that covers in depth as many subjects as this does, you will have people polarized at both ends on every issue and in between those two poles. I think the important thing at this particular point in time is not to have the whole document put on the shelf someplace, but referred to someone who can use it as a document from which to start further study and thinking about changes that ought to be made. I would like to see the report referred to a permanent committee of the House of, say, nine members who have rotational status who would continue to work on the matter of planning, be independent to look into various aspects of health care, all the other things that are involved, and that for purposes of continuity, the House select one trustee to sit on this committee. He would be one of ten people for input purposes but have enough members of the House on the committee to keep it a committee solely responsible to the House, which is a policy-making body and responsive to the House. In this way we could get away from the hassle which we are going to go through on the Himler Report.

CHAIRMAN: I would like to now ask for consensus of opinion of all present relative to Dr. Steen's proposal that we institute a resolution which will encompass the attitudes and ideas that he set forth to make this a committee of the House.

DR. KERR: **I move that we do this. (Many seconded and the motion passed.)**

CHAIRMAN: We are ready for Dr. Steen's resolution on the Himler Report, which resolves that the report of the Committee on Planning and Development be referred to a new committee on planning of the House of Delegates of AMA.

Dr. Steen read the resolution and the Board of Trustees moved to introduce it to the AMA House of Delegates.

Reports of Guests

CHAIRMAN: We will now hear the report of Dr. A. C. Offutt of the Indiana State Board of Health.

DR. OFFUTT. (Dr. Offutt referred to several pieces of legislation including the one on emergency medical care, which will be introduced to the State Legislature). One will include the ambulance law, the matter of ambulance equipment, ambulance training, much of which will be accomplished by placing in the legislation certain standards on which we can draft regulations.

We proposed to revise the act on the tuberculosis testing of school children to change the type of tests, and a revision of the act concerning the reporting of the immunization of school children. All this amounts to is placing german measles as a reportable immunization.

We still have problems with respect to local medical planning. Seventeen groups have been recognized. Several others are ready for examination. In some instances recognized bodies apparently are not being heard locally.

DR. NEUMANN: Would you comment on what the anticipation is on combining comprehensive health planning and RMP, if any?

DR. OFFUTT: I thought until recently that there would probably be some action taken very soon. One group says that the two programs will be closely tied together. Another group says they will be separated. So I don't know what actions are going to be taken.

CHAIRMAN: Now we will hear from Mr. Richard Kilborn, Executive President of Blue Shield.

MR. KILBORN: Concerning the recent rate increase for the physicians' own Blue Shield account, there were about 200 doctors who applied for major medical, and there were about the same number who switched back to the basic contract. So we lost roughly about 100 doctors because of the increase, but we gained about 100.

Concerning Medicaid, our main problem has been and still is the eligibility problem. The physician can pick up an eligibility number from the local welfare department or even a card from the beneficiary himself that looks perfectly good and send it in to us, and then receive a note from us that the person is not eligible. The reason for this is that these people can change roles. If they change to old age survivor or another category, they automatically have a new number, and the local welfare has to give the provider the new number before the claim will go through. It is surprising to me how many of these people change roles.

We manned our operation to accommodate claims for 15,000 claims per week. Currently we are receiving 35,000 claims a week. Most of it is for drugs. Concerning the number of claims we are receiving per week, 28,500 are from pharmacists, 5,000 approximately from physicians, 550 from dentists, 290 from optometrists, 80 from podiatrists, and 500 from all other sources including ambulance, nursing homes, etc.

To date we have received 445,000 claims. We have paid 363,000 of these. Our total payment is $2,194,490.92. We feel that by the end of July we will be completely current, and we have pretty good assurance that this will happen.

For the Medicaid program we now have signed up 2998 physicians, 828 dentists, 915 pharmacists, 476 optometrists, 193 podiatrists, 207 chiropractors, and 732 all others, which mean ambulance service, suppliers, etc.

DR. STEEN: I would like to ask a question. Is it possible that the turnover of categories change approaches 30%?

MR. KILBORN: The state welfare department people came over and audited these rejections. Of the rejections we had, 50% of them were because the physician's office—the provider's office—transposed numbers and sent them in.

DR. STEEN: The second point I want to ask is that I have heard repeatedly dissatisfaction with your profiling for office visits, and I would like to ask where Blue Shield got a physician's profile for office visits inasmuch as, to the best of my knowledge, Blue Shield has not had any contracts in the past in which they have provided pay for an office visit, and therefore I should like to know where you got the profile.

MR. KILBORN: We have had and do have several accounts—admittedly not all through the state of Indiana—that do have office call coverage. (Mr. Kilborn cited several industries and plants throughout Indiana, including the northern part of the state a firm with 600-700 people, one in Evansville with 200-300 people, one in Lafayette of around 400-500 people. It was

pointed out that there were several other accounts in Indiana.)

We have our major medical contracts that also cover office calls once they reach deductible, and we have a pretty good percentage of our entire membership that have major medical contracts. Now, to further answer your question, we had very meager information in the beginning. We started out to the best of our ability, as we did in everything else where we did not have statistics. Profiles were based on these statistics which we built over a year or two-year period, and readjusted our coverage for office calls.

DR. STEEN: Based on regular business which is the only item we can really consider, do you consider these samplings of some 1,000 people out of a population of 4 million people an adequate sampling upon which to base your statistics?

MR. KILBORN: No, sir. When we started out on Medicare, we had real good figures on in-hospital medical care, on surgery, even on anesthesia, but admittedly we don't know a thing about suppliers for example. We had never paid for orthopedic appliances. We didn't know much about home call or office call coverage. You are right. But now I think we have very good figures.

DR. NEUMANN: In the last few weeks, about 12 to 15 of the Lafayette doctors are suddenly becoming aware of the fact that some of the patients they have been treating for the last five months actually are Medicaid recipients. Now, is there a time limit in which these people have to file?

MR. KILBORN: No, I think they have a one-year time limit. We ask that claims be submitted within 60 days but to my knowledge there is no time limit other than a year.

CHAIRMAN: Mr. Pete Foster, President of SAMA, will be our next speaker. Mr. Foster.

MR. FOSTER: I want to thank you for your great generosity in donating a certain sum of money to SAMA which enabled us to send two delegates to the national convention along with other students who were interested in some organized student medicine.

I want to read from a letter I sent to Dr. Steen, just a couple of paragraphs: "As recently as five or ten years ago much of what was discussed and voted upon at the national SAMA convention would have been considered so controversial and radical that many physicians might have shuddered in fear of the direction the profession's young members were headed. And some few of the resolutions will undoubtedly still turn heads in disbelief. Yet I feel what impressed me as much as anything was that such a great number of these issues which have demanded attention for so long and are still ignored by many state medical associations are currently being wrestled by our ISMA in the national AMA."

Just a few examples of these: I only attended a few meetings last year, but I witnessed debates and discussion on several pertinent things—abortion, the problem with legality and illegality, problems with peer review and peer review with some power behind it, decreasing medical school training, problem of giving students another opportunity other than service abroad in the armed services, to serve in the ghetto if his conscience dictated or it was deemed he was necessary there, removal of cigarette machines from hospitals, and others.

As you know, the ISMA was among the leaders in the now vastly growing trend to grant seats in the House of Delegates to SAMA members. This was designed to create a means of communication and feedback to the sometimes forgotten segment of the medical community, the student physician. A number of ISMA commissions will also again have student participants on them.

Don Dian this morning spoke to the Commission on Medical Education and Licensure about MECO which is Medical Education Community Organization. It is a plan to get students, mainly after their freshman year, out into some of the local community hospitals involved with some of the physicians and hospitals in clinical situations, hopefully not only to gain clinical experience but to perhaps interest him in some real-life community situations, possibly so that we could keep some of the students graduating frrom Indiana University Medical School in Indiana and on some of the local community levels.

This year, possibly, what basically I am struggling with, is a lack of interest by some of the new physicians graduating. They tend to shun organized medicine. They say, "It is no good. We don't want it." And I think this is not true. We need organized medicine and I think possibly through SAMA, with the help of ISMA, we can try and engender interest in the new physicians graduating. Hopefully, sometime next year I will be able to organize, with the help of the ISMA, a meeting with the students describing in some fashion just what goes on in state organized medicine. I think it needs to be brought before the students. I think this is very important.

I would like to submit to you that you at least think about the possibility of taking one student to the convention for possibly two or three days hopefully to attend pertinent resolution committees. I have one student who has voiced an interest and who is very well qualified. I would be willing to discuss his qualifications with anyone.

In closing, I would just like to say that as president of SAMA this year, I am willing and have a great desire to work with you. Hopefully we can bring about some good will between the students and organized medicine. Thank you very much.

CHAIRMAN: Next report will be from Dr. Robert Stonehill of the Indiana Regional Medical Program.

DR. STONEHILL: We now have 11 active projects going on within the IRMP programs and we have our coronary care project which I think has become rather well known throughout the state. We try to help develop coronary care units in the various hospitals. Our stroke program has now been able to bring better physical therapy, occupational therapy and speech therapy to 34 hospitals. There are programs going on in Indianapolis. These are Metropolitan Health Community Health centers which we help to finance.

We have the Nursing and Coronary Care Training program being given by Indiana University which is the training of nurses for manning units which are being developed. We have the Chronic Pulmonary Disease Program which is a very viable program being done out of the Veterans Hospital. We are taking men to 13 communities throughout the state who have an interest in respiratory diseases and giving them special five-day courses in respiratory diseases.

(Dr. Stonehill went on further to elaborate on certain aspects of these diseases.) He added: "The school of medicine library, as you know, has an extension service which is available to most physicians in the state if they contact their local library. This is TWX'd in and their request then is taken in to the school library and within 24 hours we attempt to get reprints of articles back to them. We have helped to extend this program further to other communities and we now have 94 communities that have this service available. The final two programs we are currently working on are the Health Manpower Recruitment Program with Health Careers, Inc. in which they are trying to interest high school students in health career fields, and health hazard appraisal, a special program at Methodist Hospital, Indianapolis."

Reports of Committees and Commissions

CHAIRMAN: Our next report will be from Dr. Norm Booher.

Dr. Booher discussed the legal opinion which had been rendered by the attorneys of the association and commented that the

opinion does state that the association can change the word from "recognition" on the placard issued to the voluntary health associations to the word "approved." He stated further, "Now today I would like to get your approval, if you see fit to extend it, to furthering the commission's work to the lay public. We feel that we should send the approved list to the public news media."

Dr. Booher further pointed out that the list of approved voluntary health agencies could be extended to other state organizations such as the Indiana State Chamber of Commerce, local chambers of commerce, Junior Chamber of Commerce, Better Business Bureau, the entire membership of the Indiana State Medical Association, Woman's Auxiliary of this ISMA, the Dental Association. and listed several other organizations to which this list could be sent.

He also read to the Board of Trustees a covering letter which he proposed to send to each one of these organizations explaining the work of the commission and the state medical association in its work with these voluntary health agencies.

Dr. Steen moved approval of the commission's report, it was seconded and passed.

CHAIRMAN: Dr. Jerry Holman who is chairman of the Commission on Governmental Medical Services will now report.

DR. HOLMAN: The Board of Trustees had asked this commission to investigate the matters of Medicare and Medicaid.

Dr. Holman went over several claims on Medicare and Medicaid and then proceeded to report on a recent meeting of the commission at which he read the letter from Dr. Steen and Dr. Petrich regarding the inequalities of Medicaid and Medicare. He went on, "Volumes of complaints were considered very heavy, so we were told. Requests were made that this commission make services available to study and investigate these complaints, if they were all documented and properly presented in an understandable form."

Dr. Holman pointed out that Dr. Mastrangelo, a member of the commission, moved that the Commission on Governmental Medical Services not be appointed as a claims investigating committee but only to promulgate and adjudicate outstanding claims. **The motion was seconded and passed.** A finalized joint motion was made by Dr. Mastrangelo and Dr. Trachtenberg, also a member of the Commission, as follows: "In view of the information produced by the Blue Shield representative today, June 10, that their operational procedures in processing claims seem to be faulty, this has produced erroneous and inaccurate communications to patients, which has been the cause of much concern and despair on the part of the physicians of the ISMA. No attempt has been made to inform the public or the physicians that the faulty operations have occurred and originated in the Blue Shield office. We suspect that there has probably been some gross fiscal mismanagement of federal and state funds in the administration of this program. Furthermore, we have been led to understand that the county welfare organizations have not communicated properly and efficiently with Blue Shield. The commission believes that all the above mentioned have not been in the best interest of the physicians and the taxpayers of Indiana. Because this situation still exists and will, at least until July 31, 1970, we recommend to the Board of Trustees that they secure legal counsel to protect the rights and interests of the physicians of Indiana. The counsel's course of action might be to recover damages for unpaid bills and/or seek a new fiscal intermediary for Medicaid and Medicare, possibly. This contractor could be the ISMA. Action on the above will certainly encourage physicians to continue participation in the program."

CHAIRMAN: I think the outstanding action of the commission is that we do something about a committee to organize and operate to receive grievances, complaints relative to Blue Shield on the governmental services programs and the second request has to do with the question of whether or not Blue Shield should be the intermediary for the Medicaid program. Is there any action on the part of the Board?

DR. STEEN: I heard the action of the committee in voting not to serve as a claims review mechanism or as any assisting body, but I think we do have to have a committee to do this. I think your commission is the most appropriate body to do this, and I think it is appropriate that this remain in the commission in spite of the vote you took. And I wonder if you would be kind enough to have your commission reconsider serving in this function. The Board has been criticized in the past for usurping functions from commissions. This is a governmental medical program and I think it rightfully belongs in your commission.

DR. DUKES: I think this is a good place to get the district board men of Blue Shield involved. I think maybe they can do something about it.

CHAIRMAN: On unpaid Medicare claims of 90 days or older I have quite a stack of responses and I have turned these over to the headquarters office because I feel there must be a mechanism within the state association. I think that we ought to consider a complaint mechanism for the Blues or any insurance carrrier on ordinary insurance business. When a physician hasn't been paid his fee and he has not reeeived fair adjudication, he really doesn't have very many places he can turn to in the state association once he has gone past the local level and then was turned down.

I would like to see an all-encompassing group, one that could deal with insurance business on a general basis and also one which would cover the governmental medical services that we have to deal with. Would someone make a formal proposal that the thirteen representatives of the Blue Shield Board nominated by the districts and elected by the Board serve as a grievance committee?

DR. DUKES: **I would so move.**

DR. STEEN: May I suggest, Mr. Chairman, that our Board resolve that such a committee be appointed by the president and the chairman of the Board in accordance with what they deem to be appropriate and workable. And give us a little time to think about it.

The Board passed the motion that a committee be appointed by the chairman of the Board and president.

CHAIRMAN: We will now hear from Dr. Nester, Chairman of the Commission on Public Health.

DR. NESTER: The Commission on Public Health asked me to present to the Board of Trustees two proposals for legislation. The first of these deals with the reporting of venereal disease findings by clinical laboratories to the Indiana State Board of Health. We did send a communication to the members of the Board of Trustees as of June 4, 1970, in which this proposal was given. Such reporting by laboratories to their state board of health is required in 31 states. It has been found very useful in those states in bringing to treatment persons on which there was a positive laboratory report and in which the patient was either a blood donor or a patient in the hospital or a one-visit only patient. Such persons seek employment in some corporations and fail to be employed with nothing ever done about the positive laboratory finding. These have resulted in about 33 unknown infections per 100 cases reported. So we recommend that this legislation be proposed and recommended to the next session of the General Assembly.

The other legislation concerns an amendment to the Public Health Code which would permit the local boards of health, local health officers, through their boards of health, to employ additional legal service in addition to the prosecuting attorney. At the present time, the only legal aid

which the health officer and the local health boards have is through the local prosecuting attorney and these are sometimes so overloaded with other legal matters that they do not have the time to offer consultation to the local boards of health and to assist in preparing affidavits. Some local boards of health have employed such attorneys but there is not legal authorization for this. This would allow this to take place. There are situations where, due to conflicts of interest, the local prosecuting attorney is prevented from taking legal action when it should be done. Here again we the commission unanimously recommend the passage of such legislation.

DR. WILHELMUS: The Vanderburgh County Medical Society wanted me and urges me to definitely speak against this legislation. They do not want to see medical care involved with more governmental politics. Quote: "It would create government interference in the doctor-patient relationship. Secondly, it is a law that would defeat its own purpose because both the patient and physician would tend to evade it. The physician would either treat the case without taking a smear or do all their own smears in their office." So I am vigorously opposing this legislation of reporting it to the state board of health.

DR. SCHUSTER: I would like to speak on the other side of that. I think that it is spelled out in this communication from the commission. It says that the state board of health shall not under any circumstances contact the patient or the potential contacts until diagnosis has been made and reported by the attending physicians. In other words, there is nothing the state board of health is doing to interfere with the doctor-patient relationship.

I think that it is incumbent that every physician recognize public health problems; and if the venereal disease rate is going up and doctors are using the excuse they can't treat people because they have to report it, I think it is just an indictment upon them and their honesty. And I strongly support this recommended legislation. **I move that the Board of Trustees approve the commission's recommendation and pass this on to the Commission on Legislation for implementation.**

There were a number of seconds and the motion was carried.

The second motion, concerned with legal advice, was also passed by the Board.

DR. NESTER: I would like to discuss one other matter. Resolution 69-11 of the Indiana State Medical Association was concerned with the necessity of school employees' tuberculin testing or x-raying. The resolution was discussed at length and Dr. Offutt and Dr. Henry, the consultant of the Indiana State Board of Health on tuberculosis, were both present. It was recommended that the legislation remain with the exception of the removal of one word from the act and that is the word "physical." It would then read, "Every Board of Education shall require an annual examination for tuberculosis" not a physical examination, "including adequate laboratory tests" and so forth. The other matter was the type of test involved and it is still maintained that the Mantoux Test is the best, which should be used because this does allow for accurate measuring of the degree of reaction.

CHAIRMAN: We will now hear from Dr. Merritt Alcorn.

Dr. Alcorn referred to proposed legislation which had been presented to the Board by a representative in the Indiana General Assembly. It was pointed out that the representative had met with the Board of Medical Registration and Examination and had been very angry about the attitude of the board in licensing physicians. Dr. Alcorn further pointed out that the legislation which the representative is proposing would not work. He said: "You cannot just open reciprocity to foreign governments which is what he is proposing. He mentioned Western Europe and perhaps we could have reciprocity with West Germany. But certainly not with many of the less developed countries in which the medical schools are open to everybody that can pay the fee, are poorly staffed and education very minimal." He added, "We have responsibility to other states because we endorse each other and we are trying to standardize the foreign graduate regulations as much as possible throughout the United States. We have a responsibility to support reasonable laws. I would suggest that we could discuss giving up this three-year residency requirement before we will endorse a foreign graduate. I think that if we can show good intent and that we are trying to help the situation as much as possible, we can keep this sort of thing from going through."

CHAIRMAN: Dr. Alcorn, thank you very much. I appreciate your staying and reporting this to us and giving the Board the opportunity of hearing your thoughts on the subject. This will be an item on the agenda at the next meeting. We will now hear from Dr. Neumann who represents Dr. Conway, chairman of the Commission on Medical Economics and Insurance.

DR. NEUMANN: On the matter of disability insurance, Mr. Townsend presented the commission with a report on the present disability insurance and in this case he indicated participation has continued to increase at a moderate rate. In the week preceding May 21, they received an average of one application a day. They now have somewhat over 400 ISMA members. The loss ratio has been exceptionally good.

The commission feels that a better selling job should be done and would ask that the Board of Trustees approve the idea that the company be given permission to solicit the new members or other members, either by appearance at the county medical societies or by mail or by personal solicitation, with the understanding that this is a supplemental program with their own individual coverage. It seems to me a stable program, and it seems to have substantial merit. In our own society, the new members have been interested in this, and the only information they do get is again the orientation brochures we have been giving them from the state association.

Dr. Harshman so moved and the motion was passed with the stipulation that the commission enjoin Mr. Townsend not to harass the physicians about this. It was pointed out that if they say no, not to pursue the matter.

DR. NEUMANN: We have looked at a group life insurance program and you have the summary of rates before you. They reflect a relatively low rate, we think, in comparison with the other programs that have been available. And this is an individual policy, written on a group basis which is convertible at any time and has the usual stipulation regarding this. If it is the desire of the Board of Trustees that the commission go further into this, then we would want your approval to be able to go forth with this and include it in the insurance package that would be offered to the association members.

CHAIRMAN: **Dr. Steen moved the approval. Seconded by Dr. Schuster. Passed.**

Dr. Neumann lastly referred to a meeting between the joint operating committee of Blue Cross-Blue Shield this week to discuss changing computer operations..

CHAIRMAN: Is there any old business?

DR. STEEN: You will remember in my address at the House of Delegates last fall I strongly recommended a Medical Disciplinary Board be studied by the Commission on Legislation, and this was accepted by the House. And inasmuch as the legislature meets in January and inasmuch as the Board of Trustees really ought to have an opportunity to look at this and discuss it and study it, I wonder if we should not encourage the Commission on Legislation to study this particular recommendation?

CHAIRMAN: **Accepted by consent.**

DR. STEEN: Number 2. I would call to your attention that in the report of the coordinator of RMP, he listed 11 areas in which they are operational, and I see six of these five service areas and five of them are educational. I noticed that out of 11 areas, one of which is not operational, five are Marion County oriented. I think that unless we take some leadership position in this thing in either directing it or leading it, we are going to find ourselves with problems later. I think the Board has a responsibility to do this.

DR. SCHUSTER: **I move that the chairman appoint an ad hoc committee to carry out further investigation of this item as mentioned by the president. Motion was passed.**

DR. STEEN: At the meeting in Florida, we tabled a motion to pay in-state speakers fifty dollars at the state meeting, and it is still on the table. I think we ought to resolve it.

CHAIRMAN: Is there a motion to remove this from the table?

CHAIRMAN: **Hearing no motion to remove it from the table, there will be no further action on the honorarium for in-state speakers.** We will now proceed to new business.

The Board then discussed at great length the Governor's Commission on Medical Education and its present approach to the problem of medical education in Indiana.

Dr. Steen moved that the Indiana State Medical Association have nothing to do with promulgating this program. **The motion lost for want of a second.**

Dr. Clark pointed out that he had two men from his district who were ineligible for reappointment to commissions and asked if this could be changed.

He was advised by Chairman Petrich that this was written into the Constitution and Bylaws and that a resolution recommending a change could be introduced to the House of Delegates.

There being no further business, the Board adjourned to meet again at 10:00 a.m., Sunday, July 26, in the headquarters building.

EXECUTIVE COMMITTEE

Saturday, July 25, 1970

The meeting was called to order at 6:00 p.m. by Donald M. Kerr, M.D., chairman.

Roll call showed the following present: Donald M. Kerr, M.D., Burton E. Kintner, M.D., Lowell H. Steen, M.D., Malcolm O. Scamahorn, M.D., Peter R. Petrich, M.D., Lester H. Hoyt, M.D., Hugh K. Thatcher, M.D., Frank B. Ramsey, M.D., and James A. Waggener.

MINUTES OF JUNE 13th MEETING—The minutes of the meeting held June 13 were approved on motion of Drs. Steen and Petrich.

MEMBERSHIP REPORT was reviewed and approved by consent.

Membership report as of June 30, 1970:	
Number of members as of Dec. 31, 1969	4,482
1970 members as of June 30, 1970:	
Full dues paying	3,915
Residents and interns	83
Board remitted	56
Senior	352
Honorary	3
Military	38
Total 1970 members as of June 30, 1970	4,447
Total 1969 members as of June 30, 1969	4,442
Number of AMA members as of Dec. 31, 1969	4,330
1970 AMA members as of June 30, 1970	4,280
Full dues paying	3,750
Exempt, but active	530
	4,280
Number who have paid state dues but not AMA dues as of June 30, 1970	164
Number who paid state dues but not AMA dues as of Dec. 31, 1969	152

Headquarters Office

PURCHASE OF OFFICE EQUIPMENT—The secretary reported he had purchased two adding machines and a file cabinet; one adding machine and one file cabinet for the CHAMPUS Department, for which the association would be reimbursed, and one new adding machine for the bookkeeping department. His actions were approved by consent.

INDIANA CHAPTER, AMERICAN SOCIETY OF INTERNAL MEDICINE—The secretary reported that the Indiana Chapter of American Society of Internal Medicine was moving their office into the ISMA building and this was the first specialty group to move in.

The president suggested that the secretary write a letter of welcome on behalf of the association to the Indiana chapter and hoped this will be the start of additional specialty organizations headquartering in the association facilities.

Treasurer's Office

The treasurer reported on the income and expenses for the month of June 1970; cash and securities report and the investment account. The report was adopted on motion of Drs. Hoyt and Petrich.

Organization Matters

SENIOR CITIZENS' JAMBOREE—An invitation to purchase exhibit space for a First Annual Senior Citizens' Jamboree to be held at the Fairgrounds was declined on motion of Drs. Steen and Hoyt.

JOHNSON COUNTY MATTER—A letter from Blue Cross Hospital Service addressed to the Johnson County Medical Society concerning physician's written notice for x-ray examinations was reviewed for the information of the committee.

ABORTION COUNSELING INFORMATION AND REFERRAL SERVICES—A letter from the Abortion Counseling, Information and Referral Services of New York offering to arrange abortions for women was read and the secretary reported that this organization had been checked with the Medical Society of the State of New York and they do not endorse this organization or its program. The matter was therefore taken for information.

LETTER FROM HEW—A letter from the Department of HEW calling attention to the California Medical Association's evaluation of Medical Staff Activity Programs was reviewed and taken as a matter of information.

LETTER FROM GENE S. PIERCE, M.D.—A letter from a physician in New Albany who is desirous of obtaining rules and regulations for forming an organization to be known as the "Indiana State Association of Physicians' Assistants" was reviewed and on motion of Drs. Steen and Hoyt, this is referred to the Commission on Medical Education and Licensure.

LETTER FROM INDIANA TRAFFIC SAFETY COUNCIL—A letter from the Indiana Traffic Safety Council soliciting the membership of the association in this organization was reviewed and on motion of Drs. Steen and Hoyt, this matter was referred to the Board of Trustees.

LETTER FROM INDIANA HEALTH CAREERS—A letter from Indiana Health Careers stating that they had assisted nine individuals in gaining entrance to schools leading toward an education in medicine was reviewed for the information of the committee.

LETTER FROM A. ALAN FISCHER, M.D.,—A letter of opinion from A. Alan Fischer, M.D., chairman of the Commission on Inter-Professional Relations expressing

his views on contributions to Indiana Health Careers was read and on motion of Drs. Steen and Hoyt, this letter was referred to the Board of Trustees.

LETTER FROM HEW—RESOLUTION ON MALPRACTICE—A letter from the Department of HEW enclosing a copy of a resolution adopted by the First National Conference on Medical Malpractice was reviewed and on motion of Drs. Steen and Petrich, this is referred to the Commission on Medical Economics and Insurance.

LETTER OF THANKS—A letter from Homer G. Hamer, M.D. expressing his thanks for the Certificate of Appreciation, which was sent to him for his service as a delegate to the AMA, was read for the information of the committee.

CHILDREN'S HOSPITAL RESEARCH FOUNDATION—A letter from the Children's Hospital Research Foundation, Inc., Columbus, Ohio, was reviewed and on motion of Drs. Steen and Petrich, the association will approve their proposed program in Marshall County with the understanding that the association's approval is contingent upon the approval of the Marshall County Medical Society.

JULY 17 ISSUE LEGISLATIVE ROUNDUP—The July 17th issue of Legislative Roundup stating the action in the Congress on the Health Training Improvement Act was reviewed for the information of the committee.

LETTER—L. H. BIBLER, M.D. A letter from Dr. Lester Bibler concerning Senate Bill 3418, currently before the Congress, which proposes to amend the Public Health Service Act for the purpose of making grants to medical schools and hospitals for the establishment of special departments and programs in the field of family practice was reviewed for the information of the committee.

Dr. Steen moved that the association refer these matters to the Commission on Medical Education and Licensure and urged that they immediately develop essentials for training of the so-called allied health personnel, the field in which they would be permitted to practice and methods of recognition, such as certification or registration. The motion was seconded by Dr. Scanlahorn and carried.

REQUEST FROM C. A. BONSETT, M.D.—Dr. Bonsett appeared before the committee to discuss the formation of the Indiana Medical History Foundation which will serve as a legal vehicle to facilitate the acquisition of the old pathology building located at Central State Hospital for the purpose of restoration of the building. Dr. Bonsett explained the use they intended to make of this building as a historical medical museum.

Following discussion, on motion of Drs. Steen and Hoyt, it was voted to enthusiastically endorse this project and to urge the members of ISMA to actively participate in making this become a reality. Dr. Petrich then moved to amend the motion to include that this information be carried in the *Journal* of ISMA so that all members would have full knowledge and would therefore be in a better position to understand our request for participation. The amendment was adopted by the maker of the motion and the second. The motion then, as amended, was put to vote and carried.

LETTER FROM THE INDIANA STATE BOARD OF MEDICAL REGISTRATION—A letter from the Indiana State Board of Medical Registration and Examination in answer to a letter of request previously sent them for review of the proposed bill for granting licenses to foreign graduates was reviewed for information of the committee.

LETTER FROM INDIANA HOSPITAL ASSOCIATION—A letter from the Indiana Hospital Association outlining some areas of interest on their part for a legislative program in the 1971 General Assembly was reviewed for the information of the committee.

LETTER FROM W. VA. MEDICAL ASSOCIATION—A letter was read from the West Virginia State Medical Association announcing they were placing the name of Carl Hoffman, M.D., in nomination as a candidate for the office of president-elect of the AMA at the 1971 annual convention in Atlantic City.

LETTER FROM HENRY G. NESTER, M.D.—A letter from Dr. Henry G. Nester, chairman of the Commission on Public Health, asking approval of the commission's support of a plan of the Indiana State Board of Health to introduce a new approach to the eradication of T. B. was read and on motion of Dr. Steen and taken by consent, this is referred to the Board of Trustees.

LETTER FROM WOMAN'S AUXILIARY—A letter from the Woman's Auxiliary to the ISMA concerning joint billing and collection of dues and seeking permission to propose having their annual convention in conjunction and concurrently with the annual convention of the ISMA was reviewed and by consent the request is to be referred to the Board of Trustees.

LETTER FROM GLEN A. RAMSDELL, M.D.—A letter from Dr. Glen A. Ramsdell seeking approval of a proposed new program for the training of Regional Center Respiratory Assistants was reviewed and on motion of Dr. Steen this matter was referred to a committee to be appointed to deal with RMP matters. The motion was approved by consent.

LETTER FROM SMITHSONIAN INSTITUTION—A letter from the Smithsonian Institution inviting the association to prepare an exhibit in conjunction with the Bi-Centennial of the United States in 1976 was turned down on motion of Dr. Steen and taken by consent.

Blue Shield Matters

The resolution adopted by the joint executive committees of Blue Cross and Blue Shield at its meeting recently was reviewed for the information of the committee.

A letter from the attorney for Blue Shield distributed at the recent Blue Shield Board meeting, together with a statement contained in an oath of office, which it was understood that members of the Board were requested to sign were read. On motion of Dr. Steen and seconded by several, it was voted to present these to the Board of Trustees and to recommend to the Board that they prepare an appropriate resolution having the effect of divorcing the Indiana State Medical Association completely from the Blue Shield Plan. The motion was carried.

Convention Matters

REQUEST OF COMMISSION ON CONVENTION ARRANGEMENTS—A request from the Commission on Convention Arrangements for payment of expenses of the medical student to appear on the annual program at South Bend was approved on motion of Drs. Steen and Kintner.

REQUEST FOR EXHIBIT SPACE FOR INCH MASTER—A request for exhibit space for the display of an "Inch Master" was read and by consent they are to be allowed to purchase space if they so desire.

REQUEST FOR SPACE FOR AAPS—A letter from Hugh S. Ramsey, M.D., inquiring about charge for exhibit space at South Bend for AAPS was reviewed and by consent Dr. Ramsey is to be informed he will be given space in the scientific section.

LETTER FROM NORTHERN INDIANA DIETETIC ASSOCIATION—A letter addressed to Dr. Bechtold from the Northern Indiana Dietetic Association asking if it would be possible for their organization to receive a written invitation to attend the clinical sessions at the South Bend meeting was read and such an invitation is to be extended. This action was taken by consent.

PROGRAM ANNUAL MEETING—The program for the annual meeting in South Bend was discussed and the secretary reported he had inquired of Dr. Kintner if it might be possible to obtain a mobile home as a give-away for the meeting. Dr.

Kintner has submitted the name of a contact with the suggestion the association might offer the company exhibit space at the annual meeting, together with one full page of advertising in the *Journal* for their cooperation.

On motion of Drs. Petrich and Steen, the executive secretary is instructed to further investigate this possibility to obtain such an offer and if successful that this be publicized to the entire membership.

Correspondence between the president, Dr. Steen, and Dr. Bechtold, local convention arrangements chairman for the South Bend meeting, was reviewed for the information of the committee.

Legal Matters

LETTER FROM JUDGE HAMILL—A letter from Judge Hamill concerning additional expense incurred by his sister as a result of the suit against Blue Cross was reviewed and on motion of Dr. Steen and taken by consent, the matter was referred to the Board of Trustees.

A bill from Judge Hamill for the suit against Blue Cross was approved by consent and a check ordered drawn in payment of his charges.

LETTER FROM ST. JOSEPH COUNTY HEALTH DEPT.—A letter from the St. Joseph County Health Department concerning the supervision of drug abuse clinics and counselling groups was reviewed and by consent this letter was referred to the Commission on Public Health for review and recommendation.

MEDICAL DEFENSE—A suit filed against a member of the association was reviewed and his application for medical defense was approved on motion of Dr. Petrich and taken by consent contingent upon his obtaining the signatures of the officers of his county medical society.

Journal

REQUEST FOR SPACE, BIO-DYNAMICS INC.—A request for the purchase of space in *The Journal* by Bio-Dynamics, Inc., was reviewed and purchase of space was approved by consent.

Future Meetings

The Communications Institute of the AMA to be held in Chicago August 6-7 was reviewed and on motion of Drs. Steen and Scamahorn, the president; president-elect; chairman of the Board; chairman of the executive committee; and the executive secretary were authorized to attend.

Announcement of a PAS and MAP Workshop in Columbus, Ohio, on August 21 was reviewed and on motion of Drs. Steen and Hoyt, no representative is to be sent.

The 30th AMA Congress on Occupational Health is scheduled for Los Angeles September 30-October 1, and on motion of Dr. Scamahorn and taken by consent, no representative will be sent.

A notice of the Second National Conference on Continuing Medical Education scheduled for Chicago October 13-15, inasmuch as this conflicts with the ISMA annual meeting, no representative will be sent.

An invitation to attend a Congress of County Medical Societies convening in Cincinnati, November 6-8 was reviewed and by consent no one will be sent to this meeting.

There being no further business, the committee adjourned to meet again at 1:00 p.m. in the Imperial House in Terre Haute, Indiana, September 12, 1970. ◄

Rich Maender thought safety belts were just for high speed driving.



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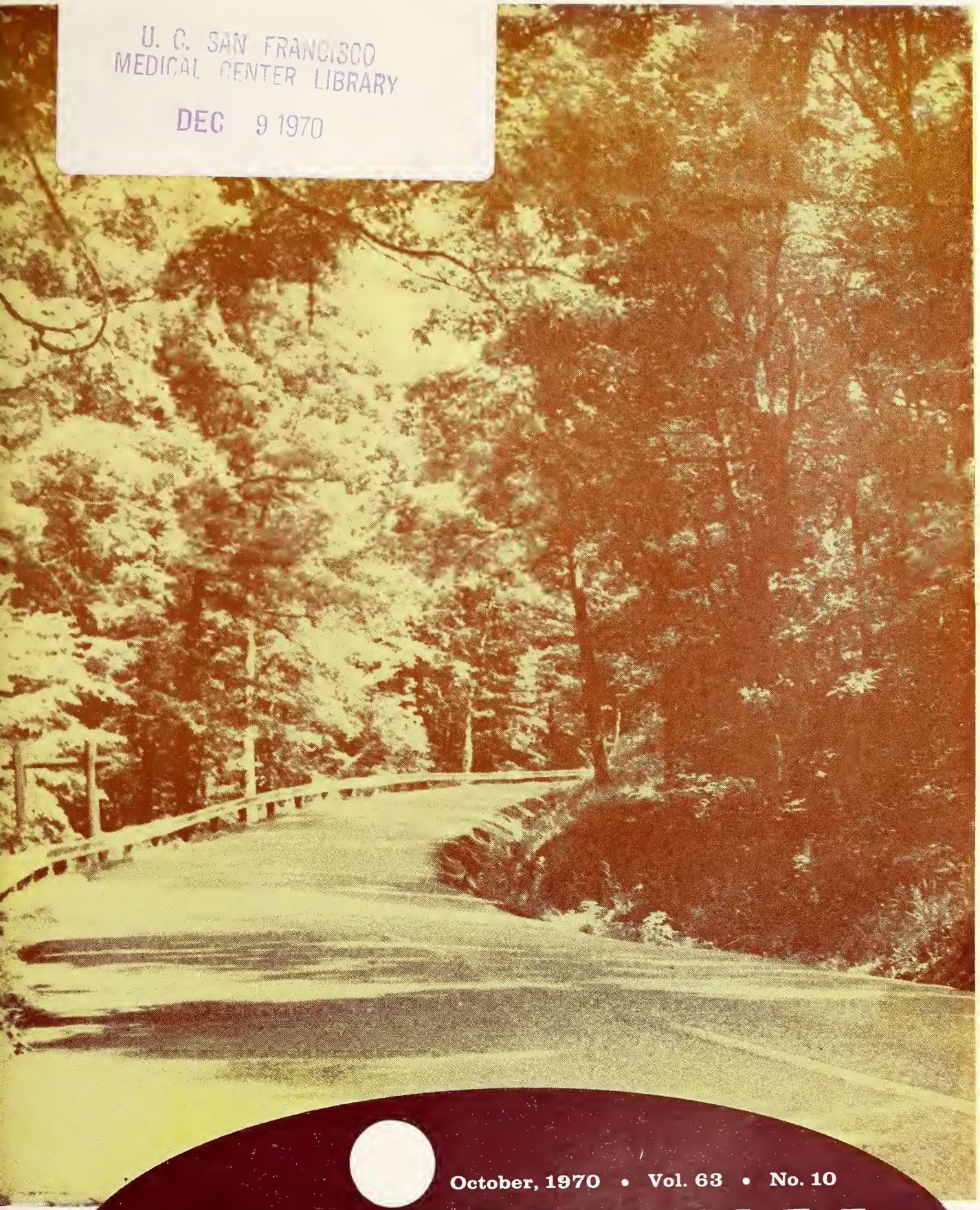
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The JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION

Indianapolis, Indiana

OCTOBER 1970

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication

3935 N. Meridian, Indianapolis, Indiana 46208

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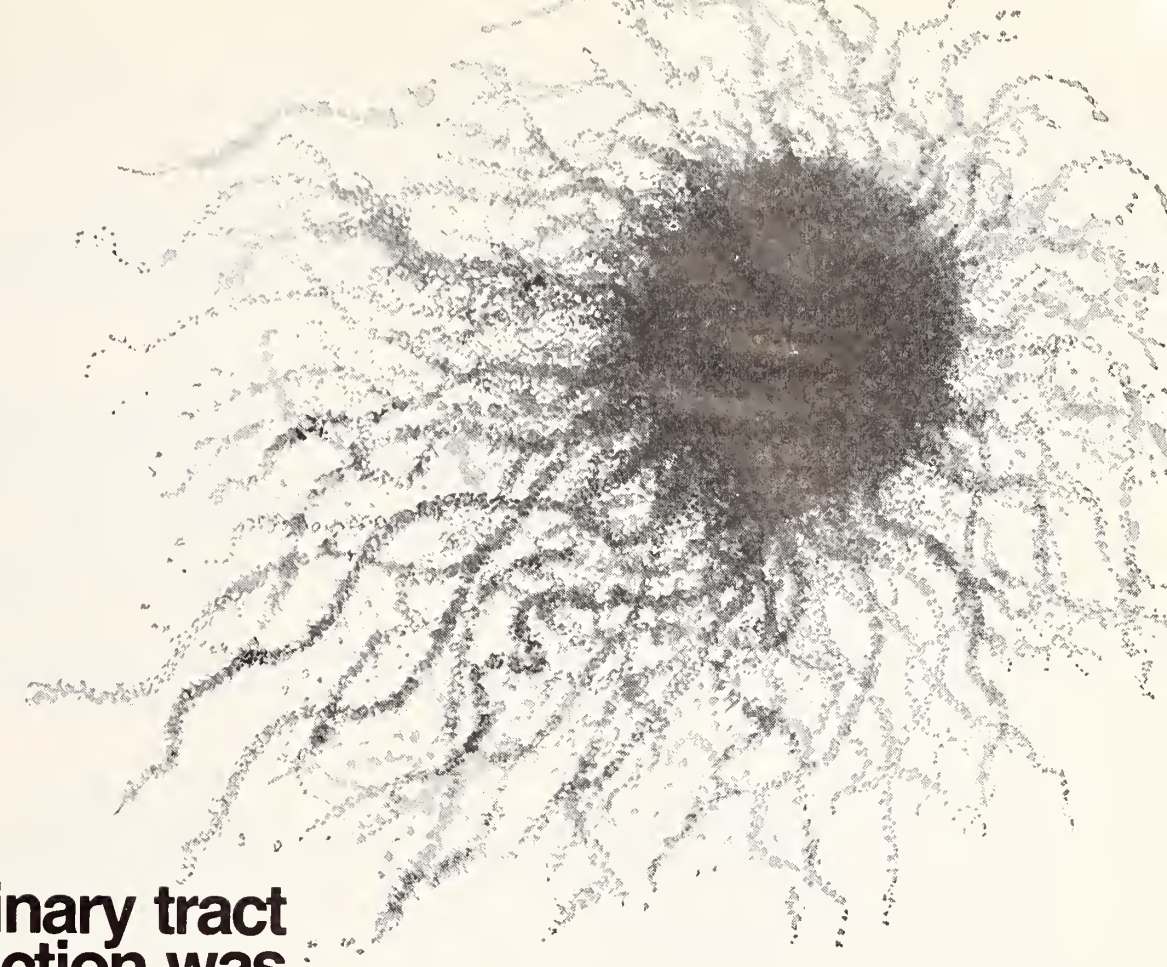
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6. Injectable form available for acute episodes.



a program for early recognition and successful treatment:

Alcoholism in Indiana*

	State Rank
total no. alcoholics	13th
no. per capita	20th
per capita consumption†	37th

Indiana Physicians' Report
(compared with U.S. average)

	%Ind.	%U.S.
see 5 or more problem drinkers in 2-month period	38.4	37.1
half or more seen are women	38.8	37.4
treat, rather than refer	73.2	72.6
more community services needed	61.7	63.0

*based on preliminary data supplied by Center of Alcahal Studies, Rutgers Univ. †absolute alcahal

The Ins-and-Outs of Alcoholism: A series of recordings and other mailings, each concerned with a particular aspect of the alcohol problem. Recognized authorities in the field discuss the scope, recognition and treatment of alcohol-dependent patients. Also included will be **The Alcoholic Directory,** a nationwide survey of treatment centers.

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INDICATIONS: In clinical studies, Serentil (mesoridazine) has been found useful in the following disease states:

Alcoholism—Acute and Chronic: Serentil ameliorates anxiety, tension, depression, nauseo and vomiting in both acute and chronic alcoholics without producing hepotic dysfunction or hindering the functional recavery of the impaired liver.

Schizaphrenia: Serentil is effective in the treatment of schizaphrenia. It substantially reduces the severity of Emotional Withdrawol, Conceptuol Disorganization, Anxiety, Tension, Hallucinatory Behovior, Suspiciousness and Blunted Affect in schizophrenic patients. As with other phenothiazines, patients refractory to previous medication may respond to Serentil.

Behaviaral Prablems in Mental Deficiency and Chranic Brain Syndrame: The effect of Serentil wos found to be excellent or good in the management of hyperactivity and uncooperativeness associated with Mental Deficiency and Chronic Brain Syndrome.

Psychaneuratic Manifestatians: Serentil reduces the symptoms of anxiety ond tension, prevolent symptoms often assaciated with neurotic components of many disorders, ond benefits personolity disorders in general.

CONTRAINDICATIONS: As with other phenothiazines Serentil (mesaridazine) is contraindicated in severe central nervous system depression or comatose states from any cause. Serentil is contraindicated in individuals who have previously shown hypersensitivity to the drug.

WARNINGS: Where potients are participating in activities requiring complete mental alertness (e.g., driving), it is odvisoble to odminister the phenothiozines cautiously ond to increose the dosoge grodually.

Usage in pregnancy: The safety of this drug in pregnoncy hos not been established; hence, it should be given only when the anticipoted benefits to be derived from treatment exceed the possible risks to mather ond fetus.

Usage in children: The use of Serentil in children under 12 yeors of oge is not recommended, because sofe conditions for its use have not been estoblished.

Attention should be paid to the fact thot phenothiozines are copable of potentioting central nervous system depressonts (e.g., anesthetics, opiates, alcohol, etc.) os well os otropine and phosphorus insecticides.

PRECAUTIONS: While aculor chonges hove not to dote been related to Serentil, one should be owore thot such chonges hove been seen with other drugs of this closs.

Because of possible hypotensive effects, reserve parenterol administration for bedfast potients or for acute ambulatory cases, and keep potient lying down for at leost ½ hour ofter injection.

Leukopenio ond/or agronulocytosis hove been attributed to phenothiazine therapy. A single case of transient gronulocytapenia has been associated with Serentil (mesoridazine).

ADVERSE REACTIONS: Drowsiness and hypotension were the most prevalent side effects encountered. Side effects tended to reach their maximum level of severity eorly with the exception of a few



(rigidity and motoric effects) which occurred later in theropy.

With the exceptions of tremor and rigidity, adverse reactions were generolly found omong those patients who received relatively high doses eorly in treotment. Clinicol dota showed no tendency for the investigators to terminate treatment because of side effects.

Serentil has demonstrated a remorkably low incidence of adverse reactions when compared with other phenothiozine compounds.

Central Nervaus System: Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, atoxio, dystonia, rigidity, slurring, okathisio, motoric reactions (opisthotonos) have been reported.

Autanamic Nervaus System: Dry mouth, nousea and vomiting, fainting, stuffy nose, photophobio, constipotion and blurred vision have occurred in some instonces.

Endacrine System: Inhibition of ejaculation ond lactotion hove been noted rarely.

Skin: Itching, rash, hypertrophic papilloe of the tongue ond angioneurotic edemo have been reported.

Cardiovoscular System: Hypatension ond tochycardia hove been reported. EKG changes have occurred in some instonces (see Phenothiazine Derivatives: Cardiovasculor Effects).

Phenothiazine Derivatives: It should be noted thot efficacy, indications and untoword effects hove varied with the different phenothiozines. The physicion should be oware that the following hove occurred with one or more phenothiozines and should be considered whenever one of these drugs is used:

Autanamic Reactians: Miosis, obstipotion, onorexio, paralytic ileus.

Cutaneaus Reactians: Erythemo, exfoliative dermatitis, contact dermotitis.

Blaod Dyscrasias: Agronulocytosis, leukopenio, eosinophilio, thrombocytopenia, anemia, oplastic onemio, poncytopenia.

Allergic Reactions: Fever, laryngeol edema, angioneurotic edema, asthma.

Hepatataxicity: Joundice, biliory stasis.

Cardiavascular Effects: Changes in the terminal portion of the electrocordiogram, including prolongation of the Q-T interval, lowering and inversion of the T-wave ond appearonce of a wove tentotively identified as o bifid T or o U wave have been observed in some potients receiving the phenathiazine tranquilizers, including Serentil (mesoridazine). To date, these appear to be due to altered repolarizotion and not related to myocardial damoge. They appeor to be reversible. There is no evidence at present that these changes are in ony way precursors of ony significant disturbance of cardioc rhythm.

Hypotension, rorely resulting in cardiac arrest has been noted.

Extrapyramidal Symptams: Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonos, oculogyric crises, tremor, muscular rigidity, okinesia—some of which on rare occasions have persisted for several manths or years especially in patients of odvanced age with brain damage.

Endacrine Disturbances: Menstruol irregularities, altered libido, gynecomastio, weight gain. False positive pregnancy tests have been reported.

Urinary Disturbances: Retention, incontinence.

Others: Hyperpyrexia. Behavioral effects suggestive of a paradoxicol reaction have been reparted. These include excitement, bizorre dreams, aggravation of psychoses and toxic confusional states. More recently, a peculiar skin-eye syndrome has been recognized as a side effect following long term treatment with phenothiazines. This reaction is marked by progressive pigmentation of areas of the skin or conjunctiva and/or accompanied by discolorotion of the exposed sclera and cornea. Opacities of the anterior lens and cornea described as irregulor or stellate in shape have also been reported.

DOSAGE AND ADMINISTRATION: Oral: The dosage of Serentil (mesoridazine), as in mast medications, should be odjusted to the needs af the individuol. The lowest effective dosage shauld always be used. When maximum respanse is achieved, dosage may be reduced gradually to o maintenance level.

Alcohalism: For most potients the usuol starting dose is 25 mg. b.i.d. The usuol optimum tatal daily dose range is 50-200 mg. per doy.

Schizophrenia: For most patients, regordless of severity, o starting dose af 50 mg. t.i.d. is recammended. The usual optimum total daily dose range is 100-400 mg. per day.

Behaviaral Prablems in Mental Deficiency and Chranic Brain Syndrame: For most potients o starting dose of 25 mg. t.i.d. is recommended. The usuol optimum totol daily dose ronge is 75-300 mg. per day.

Psychoneuratic Manifestatians: For most potients the usual starting dose is 10 mg. t.i.d. The usuol optimum total doily dose ronge is 30-150 mg. per day.

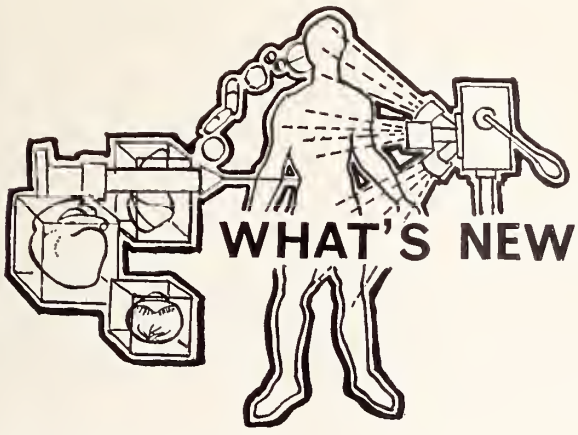
Injectable Form: In those situations in which an intromusculor form of medication is indicated, Serentil (mesoridazine) Injectable is available. For most patients a storting dase of 25 mg. is recommended. The dose moy be repeoted in 30 to 60 minutes, if necessory. The usuol optimum totol daily dose range is 25-200 mg. per doy.

HOW SUPPLIED: Tablets: 10 mg., 25 mg., 50 mg., and 100 mg. mesoridazine (as the besylate). Battles of 100.

Ampuls: 1 cc. [25 mg. mesaridazine (as the besylate)]. Inoctive ingredients—Disodium Edetate, U.S.P., 0.5 mg.; Sodium Chloride, U.S.P., 7.2 mg.; Carbon Diaxide Gas (Bane Dry), q.s.; Woter for Injection, U.S.P., q.s. ta 1 cc. Baxes af 20 and 100.

SER70-101

Sandoz Pharmaceuticals, Hanover, N.J.



Posey has a new Nylon Restraint Net for bed patients. It is a quick-drying nylon net with reinforcement at all stress points and with accessibility provided for the head, arms, and feet. It gives maximum patient restraint and one size fits all beds and all patients.

* * *

Frank Komlos is marketing a new, convenient, and compact storage arrangement for rubber stamps. It is made in four sizes for 6, 12, 24, or 48 individual stamps. Each stamp fits into a slot from which it is released in a pop-up fashion when the stamp is depressed slightly. The depressing motion inks the stamp which then pops-up into the grasp of the user. The device is attractively covered with poly-vinyl.

* * *

Biodata is engaged in the design and sale of a new stethoscope which contains an amplifying device which does not require batteries. It is called the Magna-Sonic. When placed against the body with normal pressure it operates as a conventional instrument. When pressure is increased, a ceramic magnet produces an amplification with dramatic increase in the sound level.

* * *

Dr. Charles A. Bonsett, Indianapolis, is the author of a book entitled "Studies of Pseudohypertrophic Muscular Dystrophy," published recently by Charles C Thomas. The book is a report of the results of research during the past 10 years at Indiana University School of Medicine in regard to treatment of muscular dystrophy.

* * *

"Wecolator" is a new word coined by the W. E. Cheney Company which makes elevators. They feature the Wecolator stairway elevator for those who are incapacitated or handicapped. It is custom built to fit any style staircase, comes in four colors and will match any decor.

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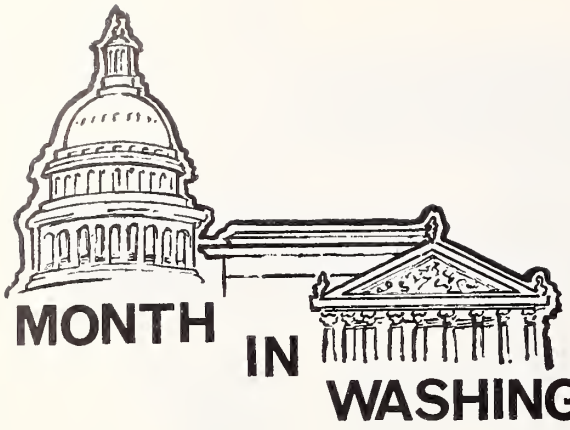
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THE CARLTON CORP

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This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

THE NIXON Administration is drafting legislation that would eliminate the reason for physicians forming professional corporations for federal income tax advantages.

THE legislation would remove the tax discrimination against self-employed physicians and other professionals in the tax treatment of retirement savings.

K. MARTIN Worthy, chief counsel of the Internal Revenue Service, said the legislation probably will be submitted to Congress next year as an Administration measure. He said the Administration intends to "remove the present discrimination between tax treatment of qualified plans for employees and qualified plans adopted by self-employed persons."

THE IRS official said that it was unfortunate that disparate tax treatment of corporate employees and professionals has led to the adoption of state laws permitting the formation of professional corporations.

"THE potential, if not actual, erosion of the traditional stringent professional standards and liabilities on the part of those who form such organizations is, in my opinion, a highly undesirable by-product of this problem and its resolution to date," he told a meeting of lawyers. "The intervention of a legal entity between the doctor, lawyer or accountant and his client would not appear to serve any social or public purposes."

WORTHY warned that recognition of a professional organization as a corporation for tax purposes did not necessarily mean that the organization and its employees would have a clear track as far as securing the tax benefits which are desired.

WORTHY said an important consideration to be weighed by the professional person is that the new tax act provides for a 50% maximum tax rate, after a transition period, upon "earned income," which includes earnings from personal services.

"IN view of this new tax ceiling, it is questionable whether a professional person would find it as important as it was previously to achieve the tax deferral available as an employee covered by a qualified pension or profit sharing plan," he said.

WIDE USE OF PHYSICIANS' ASSISTANTS URGED

THE Board on Medicine of the National Academy of Sciences urged wide use of three types of physicians' assistants as the quickest way to relieve the national shortage of doctors.

IN a special report, the board called for the cooperation of the American Medical Association, the Association of American Medical Colleges and the government in developing physicians' assistants programs.

THE AMA has been advocating use of physicians' assistants for some time. Dr. Walter C. Bornemeier, president of the AMA, recently said:

"WE of the AMA believe the shortage (of physicians) can be dramatically relieved if the physician divests himself of functions which can be performed by assistants or associates. That relief would be provided, not in ten years, but as fast as assistants could be trained—no major legislation, no huge appropriations of money are required. We are certain the plan will result in better care for more people at a lower unit cost. Much of the training given to the assistants is, and would be in future programs, on-the-job instruction in the doctor's office.

"THERE is nothing revolutionary about this plan. Until 50 years ago, American doctors trained by working in the offices of established physicians. And even with the rise of university-affiliated medical colleges, we doctors continued to train the bulk of our non-professional nurses and office technicans."

THE NAS board said that physicians' assistants could "extend the arms, legs and brains of the physician" by performing tasks that do not require the unique talents of the physician.

THE three types of assistants recommended by the board were:

1) Physician's associate—the most highly trained type; would be qualfied to do work that involves some independent medical judgment; under the physician's supervision, he could in some cases make a diagnosis and perform therapy, with the range of his responsibilities increasing as he develops new skills on the job.

2) Specialized assistant—would be highly skilled in one type of clinical specialty or procedure within a specialty (such as the operation of a renal dialysis unit); would receive most of his training from a physician specialist.

3) Non-specialized assistant—would be to medicine what the practical nurse is to nursing; could receive much of his training on the job.

AS the AMA has been doing, the board cautioned against the premature enactment of licensing laws that would establish rigid job qualifications before the full potential usefulness of the assistants had been determined. The board report recommended a system of registration that would permit physicians to employ assistants who had completed an approved program or otherwise established their qualifications.

POSSESSION of a high school diploma should be an adequate prerequisite for training to become physicians' assistants, according to the NAS Board. It suggested varying amounts of education, clinical experience and on-the-job training for the three types of assistants. For physicians' associates, it recommended the equivalent of two years of professional-level classroom and clinical work. Instruction should cover the basic sciences underlying medical practice, and clinical training should be "of essentially the same type and degree as that given medical students." Medical corpsmen, about 30,000 of whom are discharged from the military services each year, and other medical workers who enter the training program should be allowed credit for the clinical knowledge they already have acquired.

AMA OPPOSES ESTABLISHMENT OF NATIONAL FORMULARY

THE American Medical Association opposed establishment of a national formulary that could restrict the prescribing practices of physicians with respect to federally supported medical programs.

IN a letter to Sen. Russell B. Long (D., La.), chairman of the Senate Finance Committee, which was considering such legislation, Dr. Ernest B. Howard, executive vice president of the AMA, said:

"THE American Medical Association, representing approximately 180,000 active private practitioners of medicine in America, is opposed to a proposal

Continued

that would interfere with the professional judgment and responsibilities of physicians. The proposed amendment, which would give a Federal Formulary Committee the authority to exclude from the Formulary (and therefore from payment) any drug which it considers unnecessary, is, in our opinion, just such an infringement upon the professional judgment of practicing physicians.

"THE amendment would provide the Formulary Committee with authority to publish prescribing information about each drug listed. Adequate prescribing information to assist physicians in selecting the most rational course of therapy is available through a variety of acceptable sources. The proposed additional information is not only unnecessary but undesirable since physicians would be unable to deviate from that standard regardless of a particular patient's circumstances without facing the risk of malpractice liability.

"FURTHER, the amendment would require that a physician who desires to prescribe the product of a particular manufacturer with which he had experience and confidence could do so only by writing in his own handwriting the established name of the drug again and the name of the preferred manufacturer. We disagree with this practice limiting the authority of the physician to prescribe the drug of his choice. Our governing body, the AMA House of Delegates, has stated and reaffirmed on many occasions that physicians should be free to use either the generic (established) or brand name in writing prescriptions.

"IN addition, the proposed amendment would have the Formulary Committee institute inspections, sample examinations and scientific review of drug products to be listed by the name of the supplier or the brand name. This task of the committee seems to be beyond its capability, particularly since it is constituted only on a part-time basis . . . .

"WE have said many times that we want our patients to receive high-quality drugs at the lowest possible cost. We continue in this position, more strongly than ever. But, we firmly believe that the creation of a national formulary would not bring about a more economical provision of drugs under programs established within the Department of Health, Education, and Welfare, nor would it enhance the quality of these drugs."

AMA SUPPORTS FEDERAL FAMILY PLANNING and POPULATION RESEARCH

THE American Medical Association supported a senate-approved bill that would expand federal family planning services and population research activities.

IN a statement submitted to the House Subcommittee on Public Health and Welfare, the AMA said it believes the establishment of an Office of Population Affairs under a deputy assistant secretary in the Department of Health, Education, and Welfare is highly desirable. The Office would make formula or special project grants relating to population and family planning; administer population and family planning research; act as a clearing house on domestic and international population family planning programs; provide liaison with other federal agencies; and support training for manpower in these programs.

THE bill (S. 2108) also would authorize special projects for family planning services, formula grants for family planning, training and research grants, and grants for the construction and operation of population research centers.

Continued on page 1177

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THE AMA said that there is an urgent need for a greatly expanded program of population research, as authorized by the legislation.

"IF the worldwide population increase is to be controlled," the AMA said, "it will require more scientific knowledge of human behavior. We need more research on reproductive physiology, more demographic research, and more attitudinal and motivational research."

THE AMA listed a number of obstacles to be overcome if a national program for population control is to be effective: education, religion, legal and economic considerations.

"THE most formidable of these is lack of education," the AMA statement said. "Population control is only attainable when people first understand the nature of their own bodies."

MEANTIME, the Defense Department disclosed that a series of rulings this year had made it mandatory that U.S. military base hospitals throughout the world perform abortions and surgical sterilizations for armed forces personnel and their dependents regardless of state and local laws.

DR. Louis M. Rousselot, assistant secretary of defense for health and environment, issued the rulings to clarify a policy that had been effective since 1966 but which some bases had not been following.

FEDERAL SCHOLARSHIP LEGISLATION INTRODUCED

FIVE Republican senators introduced legislation that would establish a four-year federal program of family physician scholarships and fellowships to medical students and graduates who agree to practice in physician-shortage areas or to serve migratory agricultural workers.

FOR the first year, about 500 scholarships not to exceed $5,000 and 200 fellowships would be offered at a cost of $4.5 billion. The program would be expanded each year until by the fourth year 1,000 scholarships and 500 fellowships would be authorized for students and graduates agreeing to practice in isolated rural areas, migrant areas, city ghettos and Indian reservations with a shortage of physicians.

FOR each year of a scholarship, one year of service would be required. No additional service would be required under the fellowship part of the program.

SEN. George W. Murphy (R., Calif.) was chief sponsor of the legislation (S. 4208). Cosponsors were Sens. Peter H. Dominick (R., Colo.), Jacob K. Javits (R., N.Y.), Winston L. Prouty (R., Vt.) and William B. Saxbe (R., Ohio). ◄


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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

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Determination of size of failing kidneys by use of Hippuran ^{131}I aids in differentiation of acute and chronic nephritis.

The Hippuran ^{131}Iodine Renal Scan in Renal Failure

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Indianapolis

IN the patient with renal failure, the morphology of the kidneys can distinguish between acute or chronic nephritis, since loss of renal mass characteristic of the chronic process is not evident in an acute process. Other methods of determining renal size and contour such as the plain abdominal film, excretory urography, or renal scanning with mercury labeled chlormerodrin may not be helpful in renal failure, while risk of infection in a critically ill patient provides a deterrent to the routine use of retrograde pyelography. Angiography requires sophisticated facilities which may not be available.

Radioiodine labeled o-iodohippurate sodium I-131 (Hippuran-I-131) like para-aminohippuric acid, is nearly completely extracted from the blood by the kidneys.[1] Although Hippuran-I-131 is widely used for the functional renogram,[2] its rapid clearance by the normal kidney yields poor images of the renal parenchyma unless it is administered by constant infusion. Rosenthall has demonstrated that in renal failure the prolonged clearance time of Hippuran-I-131 provides favorable conditions for visualizing the renal parenchyma.[3] His findings have recently been confirmed by Freeman and co-workers.[4] The following cases illustrate how the Hippuran-I-131 renal scan can distinguish between acute or chronic nephritis associated with renal failure.

Case Reports

Case 1: A 25-year old man had seizures, became unresponsive and required a tracheostomy to relieve respiratory difficulty. A subdural hematoma on the left was discovered and evacuated through burr holes the next day but he continued to be poorly responsive to his surroundings. His urine was grossly bloody when he entered the hospital, and although he voided at least 500 ml daily his serum urea nitrogen level rose from 47 mg per cent to 180 mg percent over the next six days and his plasma creatinine rose to 13.9 mg per cent. Three days after peritoneal dialysis was begun to maintain his life, his electrolyte values were normal. After dialysis was discontinued, serum urea nitrogen once again rose to 175 mg per cent and again peritoneal dialysis was necessary. During this time he remained poorly responsive and had a Cheyne-Stokes pattern of respiration. His blood pressure was 180/90 mm of Hg and his pulse 120. A renal scan with 250 microcuries iodohippurate sodium I-131, done with a commercially available eight-inch crystal rectilinear scanner without contrast enhancement showed normal-sized

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FIGURE 1
ACUTE Glomerulonephritis. The Hippuran-I-131 scan shows normal sized kidneys with a uniform distribution of activity.

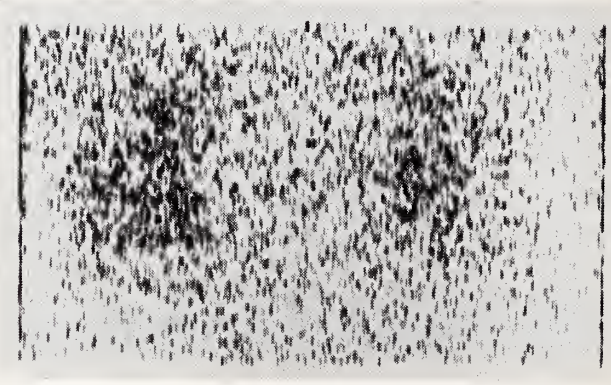


FIGURE 2
CHRONIC Glomerulonephritis. The Hippuran-I-131 scan shows small kidneys with irregular outline and areas of varying function.

kidneys with homogeneous activity in the renal parenchyma (Fig. 1). The scan findings suggested an acute process. An open renal biopsy was done and the microscopic sections showed proliferative hypercellularity in the glomeruli with a few epithelial crescents, findings consistent with acute and subacute glomerulonephritis.

Case 2: A 38-year old man had experienced drowsiness and weakness for one month and looked pale and ill. His blood pressure was 170/120 mm of Hg and his apical cardiac impulse was prominent at the midclavicular line. His hemoglobin measured 8.9 gm per 100 ml. His urine was clear, had a specific gravity of 1.014 and contained 300 mg per cent of protein. Red blood cells and white blood cells were present in the urine as were waxy and granular casts. His serum phosphate was 6.9 mEq/L but otherwise no serum electrolyte imbalance was present. The creatinine clearance measured 10.9 ml per minute and the serum urea nitrogen was 67 mg per cent. Immunoglobulin electrophoresis showed lowering of the IGG and elevation of the IGA fractions. A renal scan performed following injection of 250 microcuries of iodohippurate sodium I-131 showed shrunken kidneys with irregular margins and uneven function suggesting chronic renal disease (Fig. 2). An open renal biopsy was obtained and microscopic inspection showed changes in nearly every glomerulus consistent with chronic glomerulonephritis. The majority of the glomeruli were hyalinized, some showed adhesions between the glomerular surface and Bowman's capsul, while others showed swelling of the capillary basement membrane. The appearance of the tubules varied from normal to dilated and filled with protein casts surrounded by flattened epithelial cells. In other places fibrotic replacement of the renal parenchyma was present.

Discussion

Visualization of the kidneys is possible by the scanning technique using Hippuran-I-131 when renal function is so markedly impaired as to require dialysis to maintain life. The method is simple, readily available and carries no risk to the patient. These case reports illustrate that the accurate portrayal of renal size with this technic allows distinction of the small shrunken kidneys of chronic nephritis from the normal-sized kidneys associated with acute renal failure. Such a simple means of distinguishing acute from a chronic nephritis should prove helpful in choosing appropriate therapy.

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Two rare tumors of the rectum, related histologically, one benign and the other malignant. Discovery and differentiation are important since radical treatment offers the only hope for cure of the sarcoma.

Leiomyoma and Leiomyosarcoma of the Rectum

RAY H. BURNIKEL, M.D.
WESTON A. HEINRICH, M.D.*
Evansville

LEIOMYOMA and leiomyosarcoma of the rectum are rare tumors. Osmond and Mautz,[8] reviewing the literature in 1955, found only 20 leiomyosarcomas of the rectum reported. Later authors have reported larger numbers of these lesions, but it is still a rare lesion. The first report of a leiomyoma of the rectum was described by Van der Espt in 1881, and the first leiomyosarcoma of the rectum was described by Exner in 1908 when he reported two cases. The first extensive summary of all types of primary sarcoma of the rectum was by Lapeyre, published in 1920. In 1941 Golden and Stout[4] analyzed 60 smooth muscle tumors and included reports of three additional cases of malignant leiomyosarcoma of the rectum. Anderson, Dockerty and Buie[1] reviewed the files at the Mayo Clinic in 1950 and found a total of 10 cases of leiomyosarcoma of the rectum. Several of these cases had been previously reported. Jay,[6] writing in 1958, could find only 34 reported cases. He pointed out that smooth muscle tumors may appear anywhere in the gastro-intestinal tract but the common site is the stomach where 61.5% occur. The rectum is involved in only about seven percent; however 50 percent of the rectal leiomyomas are malignant while the majority of gastric leiomyomata are benign. Eighty-three percent of leiomyomas of the colon arise in the rectum (Golden and Stout).[4]

In 1962 Quan and Berg,[9] reporting from the files of the Rectum and Colon Service of Memorial Hospital, added 6 leiomyomas and 11 leiomyosarcomas of the rectum. In their review of the literature they stated, "to date, 78 patients with leiomyoma and 58 patients with leiomyosarcoma can be found in English medical literature". Addition of this series to the reports available in medical literature brings the total number of reported leiomyomas of the rectum to 84 and leiomyosarcomas of the rectum to 69.

Bacon and Diamante,[2] in an article in 1967 reviewed a series of 2,537 patients with malignant tumors of the colon and rectum. Fourteen of these were sarcomas with three of the sarcomas being leiomyosarcomas. The leiomyosarcomas were all situated in the rectum, representing 0.10% of 1539 tumors found in that area.

Pathology

Kalimia and Peltokallio[7] describe the leiomyomas very well. They are sharply circumscribed but microscopically a definite capsule is seldom seen. The cut surface is grayish pink and whorled. The tumors are relatively avascular. The gross appearance presents a very variated picture of inflammatory change, fibrosis, necrosis, hemorrhage and at time calcification. Microscopically there are interlacing bundles of plain muscle fibers separated by varying degrees of fibrous tissue. The tissue is quite similar to smooth muscle tumors situated elsewhere in the body.

The leiomyosarcomas are more difficult to describe. Jay[6] says that the histologic picture is that of a cellular tumor without a capsule, composed of fat elongated spindle cells arranged in bundles, which have two or more mitoses per high powered field. There is great variation in the grade of malignancy and this is revealed by anaplasia, frequent mitoses and hyperchromatism rather than extensive metastasis or early local extension.

Quan and Berg[9] found variations in the histologic characteristics of their 11 tumors. Half of the tumors had enough organization to betray their myomatous origin. There were transitions from this form through loose structure to crowded, cellular pleomorphic tumors. They, as have most other writers, point out that mitosis was common in all tumors except two. They also point out that neither cellularity nor the amount of cytoplasm correlated with the size of the tumor or its prognosis. Two of their four smallest leiomyosarcomas were the most pleomorphic, while three of the five largest tumors were less cellular and well organized.

Jay[6] describes the gross appearance of the tumor as pinkish, meaty and often ulcerated, thus accounting for the occasional rectal bleeding. Bacon and Diamante[2] point out that lei-

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omyosarcoma may be as small as 1 cm. in diameter or it may be as large as a grapefruit. It is reddish-gray and in most cases has a rather dense consistency. Degenerative changes within the substance of the tumor are not uncommon and may account for its occasional fluctuant and soft character. In the rectum the overlying mucosa usually does not become ulcerated unless the size of the tumor is sufficient to stretch the mucosa. Quan and Berg[9] also point out that ulceration of the overlying rectal mucosa was the exception rather than the rule in their 11 leiomyosarcomas. Our patient exhibited ulceration of the mucosa. The tumors arise either in the muscularis mucosa or in the walls of the blood vessels. They may grow into the lumen of the bowel or they may extend externally. The case reported by Williams[11] had extended externally and was a mass 7 x 11 x 12 cm. in size. As stated by Rankin and Larson[10], these tumors grow slowly and metastasize late. In Jay's[6] review of the literature there were 10 females and 24 males. The age range was 34 years to 76 years. In Quan and Berg's[9] series, the youngest patient was 21 years old and the oldest was aged 66 years. The median age was 52 years and the average was 50 years. In their series there were seven men and four women and all were white. The average age of the males was 43 years compared with the average age of 61 years for women. Curiously enough in this series, the two youngest men and the two oldest women had the most malignant tumors.

The chief symptoms are constipation, straining at stool, a sense of rectal fullness, prolapsing rectal mass, bleeding, and pain. All the authors whose papers were reviewed give essentially the same set of symptoms. It is interesting that in several reports the patients were asymptomatic— 5.2 percent in the table given in the Bacon and Diamante[2] report and two of the 11 patients in the Quan and Berg[9] report were asymptomatic. One patient had only rectal bleeding and a feeling of heaviness and pressure in the rectum. There was no pain, prolapse, or change in bowel habit.

The leiomyomas often will be present as a submucosal nodule.

Treatment

In their report of five cases of leiomyoma, Freund and Fisher[3] treated them by local excision. They stated in their summary "Although radical resection has been advocated, it would seem from our experience that local excision is adequate." Haas and Ritter[5] also feel that local excision of leiomyoma of the rectum is the preferred surgical approach and recommend removal of the tumor through a posterior proctotomy.

In the series of six cures of leiomyoma reported by Quan and Berg[9] two of the smallest nodules were removed in toto with biopsy forceps. Two others, perhaps somewhat larger, were excised with a cautery snare. Another nodule (2.0 cm. in diameter) was removed surgically through a posterior proctotomy. The largest leiomyoma was a pedunculated mass 4 cm. in diameter which was an incidental finding in a surgical specimen of a rectum removed primarily for adeno-carcinoma. None of these patients had had a recurrence of the tumors and all were living 10 to 12 years after treatment.

Jay[6] in his report and review of 34 cases presents several tables on results. He advises radical primary abdomino-perineal resection for all cases of rectal leiomyosarcoma. He says "of a series of 15 leiomyosarcomas of the rectum treated radically, only three have survived for a prolonged period of time. In only nine of the cases treated by abdomino-perineal resection was the operation performed as the initial procedure. Of these three have survived for periods of times varying from five months to seven years, while those patients treated by delayed abdomino-perineal resection, radiation therapy and/or local excision all died of recurrent disease. Certainly early radical surgical treatment seems indicated."

Quan and Berg[9] have a somewhat different surgical approach. Four leiomyosarcomas of the rectum, diagnosed histologically as low grade in one patient and medium to high grade in three, and measuring 1.0 to 2.5 cm. in diameter, were excised locally and nothing else was done. Apparently, the patients with these tumors were free of disease 11, 10, six, and nine years, respectively, after treatment. The largest of these tumors (2.5 cm. in diameter) appeared to be pedunculated and was excised by cautery snare. Four patients underwent abdomino-perineal resection and lived approximately one to six years. Three patients with tumors measuring 3.0, 2.0, 3.0 cm. in diameter, succumbed to the disease one, one and six years later. The fourth patient who underwent abdomino-perineal resection of the rectum had the largest tumor. It measured 15 x 10 x 20 cm. Histologically, it was of low grade and the patient was free of disease three years after radical excision. However, this patient died one year later of widespread metastasis. One patient was treated by irradiation only. He died 11 months after the diagnosis was established. Another patient underwent local excision elsewhere of a tumor which was said to be the size of an orange. Laporotomy was performed three months later at Memorial Hospital when it was discovered that there was fixed recurrent disease of the pelvis and multiple omental metastasis. The patient died seven months after the first operation. A final patient in the Memorial series was treated elsewhere by repeated incision and drainage of the "tumefaction" in the ischiorectal fossa. After the diagnosis was established, the disease had become too far advanced for radical surgery. External irradiation and administration of nitrogen mustard were given for palliation. This patient died of pulmo-

nary metastasis one year later.

Bacon and Diamante[2] say "taking into consideration all the facts, it is our belief that an abdomino-perineal excision (Miles) should be performed in all patients with leiomyosarcoma as local excision was followed by a recurrence rate of 86 percent."

Case History

A 38-year old white female was seen in consultation on December 29, 1966, by one of us (R.H.B.) because of rectal bleeding and a feeling of heaviness and pressure in the rectum. Elimination was not painful. There was no weight loss, constipation or diarrhea. There was no family history of cancer, diarrhea or tuberculosis. Both parents were living and well. The patient had had no serious illnesses. Her only previous surgery was eye surgery. She was married with three children. Rectal exam was as follows: Inspection: Skin tag anterior. Digital: Tone normal, no point tenderness. At finger tip level on the anterior wall there was a small movable mass. Sigmoidoscope: At the 6 cm. level on the anterior wall there was a 3 x 3 x 2 cm. vascular ulcerated polypoid mass (Figure 1). She was admitted to the hospital where, on January 5, 1967, biopsy of the lesion was performed. The pathology report was: "The sections show interlacing bundles of elongated cells with their cytoplasm in elongated strands containing long narrow spindle shaped nuclei. There is considerable interlacement of bundles of these cells (Figure 2). There are compact as well as clear spaces. The nuclei are hyperchromic to some degree, and there are some mitotic figures. One area shows an ulcerated surface with some fibrous tissue reaction and a peripheral exudate which is relatively acute. Another area presents a small amount of mucosa lying on top of the tumor process. Special stains show the cells to be lighter than the collagen areas excluding the tissue process as a fibrous structure. Diagnosis — Ulcerated myosarcoma of the rectum." The slides were sent to various pathologists and a definite diagnosis of leiomyosarcoma of the rectum established. On January 18, 1967, a combined abdomino-perineal resection was done by one of us. (W.A.H.) Her postoperative course was uneventful and she left the hospital on February 5, 1967. When last seen, November 10, 1968, there was no recurrence of the disease process.

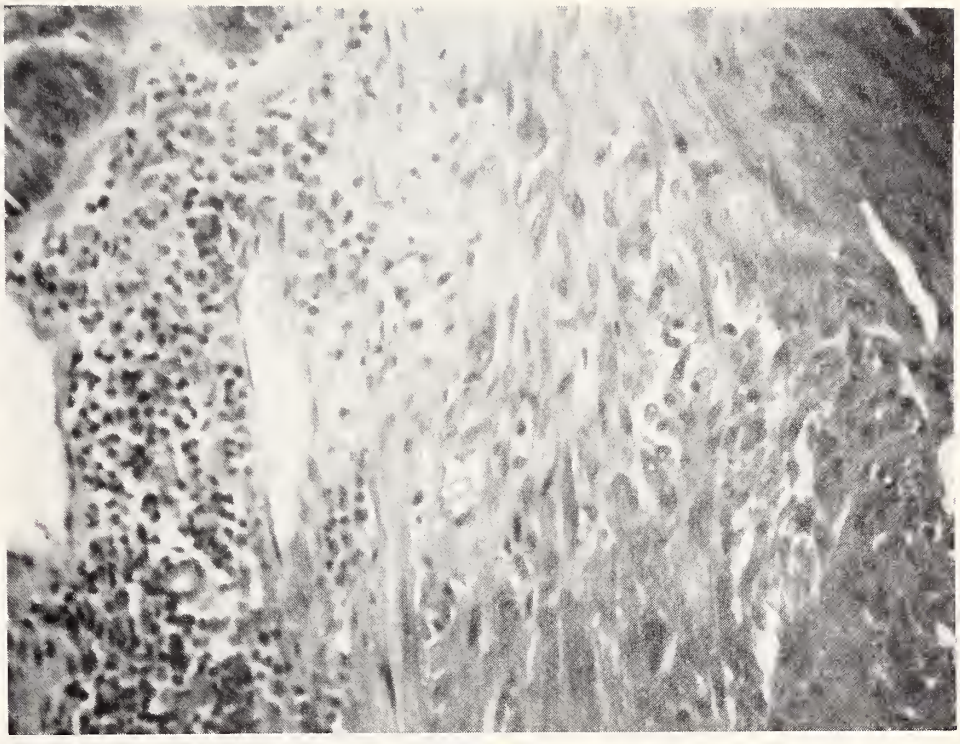


FIGURE 1
GROSS specimen (note similarity to adenomatous polyp in appearance).



FIGURE 2
NORMAL rectal mucosa to right. Spindle shaped cells of tumor, center and left.

Summary

Leiomyoma and leiomyosarcoma of the rectum are rare tumors. The available literature is reviewed. To date less than one hundred cases of leiomyosarcoma of the rectum have been reported. Treatment is discussed and it is the authors' feeling that abdomino-perineal resection is the treatment of choice when the diagnosis is firmly established.

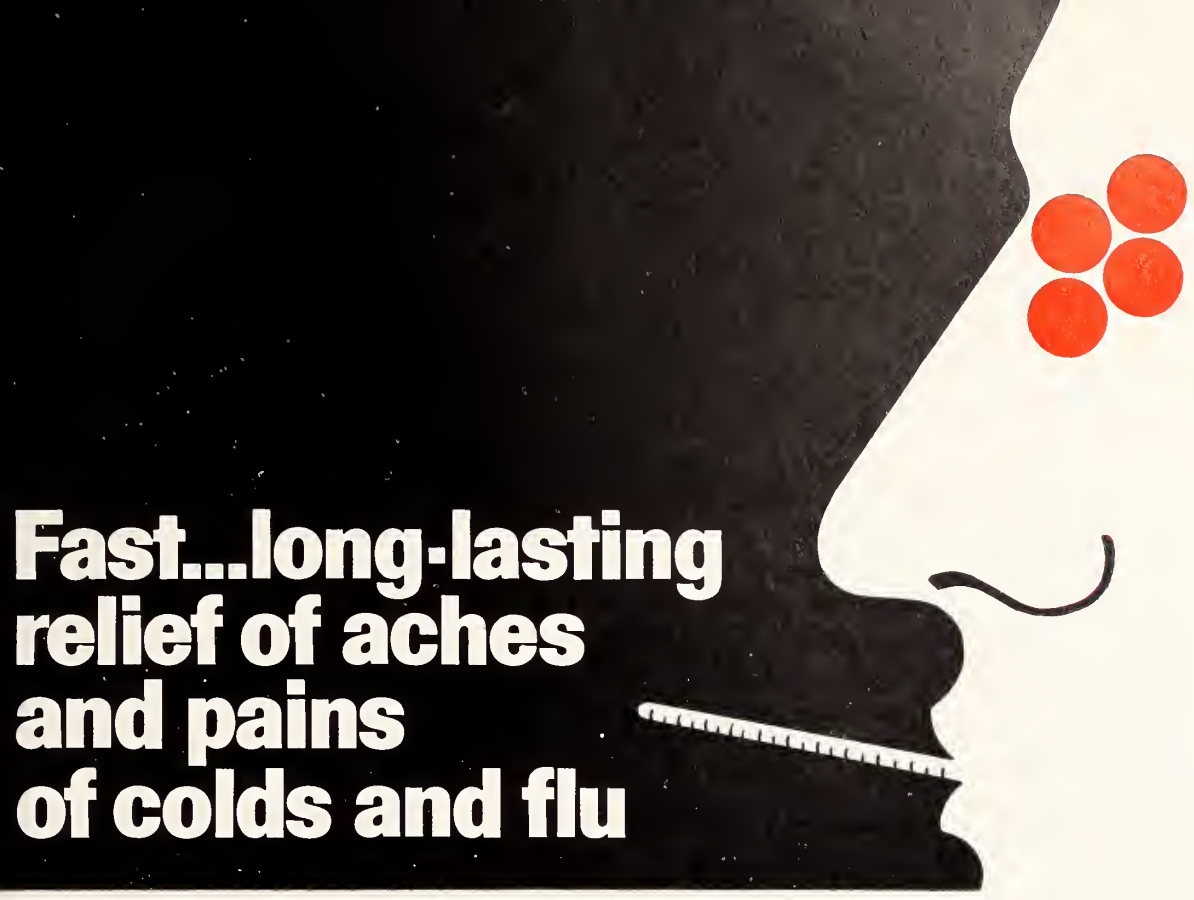
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From *The Journal* 50 Years Ago

The pediatrician is daily confronted with problems concerning the use and abuse of catharsis in infancy and childhood. Rarely is a patient brought for its first visit whose anxious parent or nurse has failed to administer vigorous and ofttimes repeated catharsis, regardless of the etiology of the disease from which their defenseless charge is suffering. Too often more harm than good has resulted from the popular conception that "a thorough cleansing of the bowels" is the essential prelude to all forms of treatment. Perhaps the medical profession is partly responsible for this conception. With a full realization of the good that is accomplished by a quick and thorough emptying of the gastrointestinal tract when indicated, I wish to emphasize the harm that may be done by the abuse of catharsis in infants and children.

The most harm is probably accomplished in the continued use of cathartic drugs in chronic constipation. The primary effect of cathartics in general, is to cause abdominal stimulation of the bowels. They act as irritants and produce the same symptoms as infections of the alimentary tract—namely, liquefaction of feces, mucus, gas, sometimes blood and pain. Their secondary effect is to induce a state of depression and inactivity which lasts much longer than the stage of stimulation. When cathartics are administered frequently and continually, their stimulating effect gradually diminishes while the sluggishness increases. It cannot be denied that in the acute and spastic type of constipation, drugs properly administered accomplish a great deal, but with few exceptions they are ineffectual in the curative treatment of chronic atonic and mechanical constipation. Constipation is often the sign of good digestion and well being in a well nourished baby who is getting enough food and gaining normally . . . . Milo K. Miller, M.D., South Bend, "The Abuse of Catharsis in Infants and Children, *JISMA*, October 1920.



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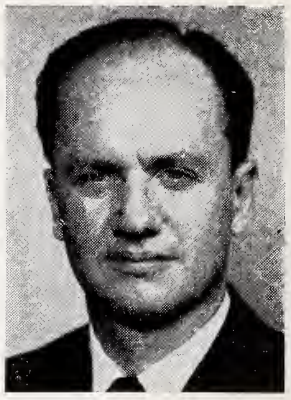
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Advances and Future Problems in Surgery*

HARVEY R. BERNARD, M.D.**



YEARLY, exhaustive discussions of what's new in surgery are printed in several of the leading medical journals, notably *Surgery, Gynecology & Obstetrics* and the *New England Journal of Medicine*. Additionally, what's new in surgery is a usual topic at the annual meeting of the American College of Surgeons. Most of these reviews are exclusively directed toward technical details.

Since these printed technical displays exist and are readily available to all, and the more especially since this audience has a broad medical background not limited to surgeons who are usually well informed about these novelties, I have decided to pattern this discourse more broadly, discussing along with the more important technical advances, areas which have newly been discovered to require solution.

This paper will, therefore, constitute both a pat on the back and a plea for improvement to the surgical profession. Several difficulties have been encountered in formulating this paper. The most difficult has been the selection of only those achievements which are likely to be of lasting importance. After all, not all that is new will prove a real advance after it has been subjected to practical testing. Next, there has been the additional problem of distinguishing between exclusively surgical advances and advances in other disciplines which have been turned to the surgeon's advantage. There is no real answer to this dilemma since virtually all research of major importance is now a multiple disciplinary accomplishment and few surgical investigations are completely devoid of a basic scientific background. In fact, the development of reverence for the basic scientific laboratory may well be one of the most important advances in surgery. Certainly, for the future, the unraveling of the knotty problems of neoplasia, congenital malformation and similar enigmas is more likely to take place through laboratory research than through improvement in technical operative maneuvers. Moreover, the surgeon has advanced in the understanding of his limitations through the acceptance of the statistical method. Although retrospective analyses of the personal glorifying experiences of single surgeons are still found at surgical meetings, more and more emphasis is being placed by the editorial staffs of journals and those selecting papers for scientific meetings upon prospective analysis, scientific control and the application of adequate statistical analysis, either by the surgeon himself or through consultation with colleagues more mathematically inclined.

Organ Exchange

First among the important technical advances must be placed the comparatively recent achievements in organ exchange. Although other forms of transplantation, especially renal and corneal, have been in widespread use for years, the successful transplantation of a human heart has thrilled the medical reader like no other accomplishment. It has undoubtedly led to an important surge of interest in organ immunology. This will probably eventuate in understandings much more valuable than the short-term extension of lives nearly terminated by lethal cardiac disease.

Human beings require stimulation and if we can avoid the devotion of too much of our energy and treasure to the simple prolongation of the lives of those few who can afford a temporary respite from inevitable death, this flamboyant accomplishment will serve a useful purpose. It is obvious that all transplantation or interchange of human organs is but a stop-gap feat which tomorrow must be replaced by prevention of the causative diseases or the use of mechanical organ substitutes devoid of the necessity of crippling one human to save another. While improvements have been made in the design of external artificial kidneys which reduce the cost of chronic dialysis, the construction of implantable kidneys and hearts is not feasible.

Meanwhile there has been an added impetus to the identification of better immunosuppressive drugs, the understanding of the role of the blood elements (especially the lymphocyte) and the construction of better immunological methods to be used in the typing of tissues and other antigens in the attempt to understand and control the rejection phenomenon.

Along with the technical advances of transplantation have arisen new problems in medical and surgical ethics which relate principally to the definition of death and the propriety

* Presented at the annual convention of the Indiana State Medical Association, October 1969, Indianapolis.

** Professor of Surgery, Albany Medical College of Union University.

of the removal of organs from willing or unwilling donors in various stages of the decay of their bodily functions. Hesitant steps have been made toward accomplishment of a uniform anatomical gifts act and greater attention has been directed at the determination of the circumstances which constitute physiologic death. Although the problem may be solved by the enactment of legislation which permits the establishment of death at a convenient time for transplantation—that is, a time when consciousness ceases permanently but at a time when the desired organ for transplantation still lives, the difficulty which is posed by this dilemma serves to reinforce the realization that transplantation of human organs is only an intermediary step in the solution of human disease, whether the eventual one is the use of organs from other animals, implantation of mechanical devices or prevention of disease itself.

Continuing with efforts directed toward improving the functioning of the heart, several advances stand out. The most obviously successful is the work that has led toward the everyday electrical control of the heart through cardioversion, defibrillation, and the use of external and implantable pacemakers which turn the lethal uncertainty of cardiac arrhythmia and conduction blockade into a fact of nearly normal, daily existence.

Revascularization of the heart wall has had its ups and downs but the recent direct approach to lesions of the coronary arteries and direct revascularization techniques must be deemed an important advance. These techniques have been associated with the use of microsurgical methods which will likely result in the salvage of many organs in the future which would otherwise be doomed to ischemic death.

Angiography Growing

Many of the foregoing accomplishments have come about in conjunction with improvements in the radiographic demonstration of smaller and smaller blood vessels. Selective angiography by directed catheterization has grown in stature such that it now permits the accurate localization of coronary artery occlusion, the diagnosis and localization of pancreatic islet cell tumors, occult bleeding in the biliary system and the gastrointestinal tract, the outline of retroperitoneal tumors, anomalies and all manner of central nervous system and extremity malformations. Suitable angiography of the heart and great blood vessels now makes preoperative assessment of congenital and acquired heart defects more certain and pulmonary angiography has put the diagnosis of pulmonary embolus on a much more certain basis. The development of an inflatable, balloon-tipped catheter which may be placed within blood vessels of varying sizes to remove recent emboli, has been a significant technical advance in the treatment of both central and peripheral arterial disease.

The recognition of trauma as an important cause of human illness is certainly an important advance in surgical therapy. Emergency rooms have grown from cobwebbed, sleepy admitting office appendages to independent departments, staffed 24 hours a day, equipped ever increasingly with their own laboratory support and performing a greater and greater share of the hospital's work.

In addition to the construction of improved facilties for the care of the traumatized, an increasing emphasis is being placed upon improved transport of the wounded and upon active prevention of injury through education and legislation to provide such things as safer automobiles and required provision of seatbelts.

The newer emergency rooms and intensive care facilities combine skilled intensive nursing care with increased availability of monitoring equipment, all of which has aided greatly in providing a smoother postoperative recovery period for most patients along with rapid and effective resuscitation for severely injured patients and expeditious recognition of urgent postoperative problems.

Recognition of the importance of attaining and maintaining adequate extracellular fluid volume has been a most important advance. Indeed, acute renal failure is now a rarity on surgical services which insist on securing a normal flow of urine prior to the induction of anesthesia. The skillful observation of central venous pressure and urine flow rate along with the usual clinical evidences of adequate extracellular fluid volume, measured and recorded at frequent intervals, provides the basis for intelligent and effective fluid management. The surgeon has been able to turn his attention from the problem of acute renal failure as the major limiting factor in his surgical abilities to a consideration of improved methods of caring for the cardiorespiratory system, the weakest link of which is the pulmonary component.

Intelligent appraisal of respiratory reserve, by simple modern tests, permits the accurate assessment of poor pulmonary risks before operation and the discovery of those patients who become pulmonary problems during their course of treatment. This permits the institution of prophylaxis in the preoperative state which includes the utilization of intermittent positive pressure breathing and the discontinuance of respiratory irritants—i.e., tobacco smoking. In addition, it allows preparation for more satisfactory care in the intraoperative and postoperative periods. Here modern improvements in controlled ventilation and oxygenation with removal of excess carbon dioxide through controlled ventilation provide an opportunity to maintain the patient in an optimal physiologic state which is now possible to assess easily and accurately by practical measurements of the tension of respiratory gases and pH. Much remains to be learned and done in this area, particularly with regard to improvement in the

safety of the equipment itself by the prevention of superinfection and damage to the pulmonary system through excessive concentration of gases and pressure. Yet enough has already been learned to establish these methods as practical advances at the present time.

The spectre of postoperative surgical infection has receded somewhat although not completely. After a brief attempt to place the blame for postoperative surgical infections on hospitals, air conditioning systems and the like—in fact anywhere but on the operation and technique itself—it has become increasingly apparent that much postoperative surgical infection originates from bacteria found within the patient himself.

Antimicrobial Therapy

Excepting those infections arising from bacteria introduced by external trauma, endogenous bacteria escaping technical attempts at preventing their lodgement constitute the major source of important postoperative infection. This knowledge provides a more sound basis for intelligent antimicrobial therapy, applying such drugs coincident with wounding when prophylaxis is desired, limiting their use to avoid superinfection and utilizing sound judgment for their employment when infection has been established. Several manufacturers are now able to supplant the presently used porous, cotton drapes and gowns with new, light, impervious fabrics and plastics which simplify draping and gowning and make these procedures worthwhile by providing truly impervious barriers.

Future advances in surgery will be predicated upon solution of some or all of the following problems: first, we must find a method for the efficient and equitable distribution of our services and the cost of these services. This must include an evaluation of the relative importance of the performance of unusual and remarkably expensive operations upon a few compared to the good that may be done for many by utilization of the same funds and personnel in the application of more standard procedures. Next, we must find a way to provide for the training of a continued supply of surgeons for the future in a society that has dedicated itself to the elimination of the poor who have traditionally served as objects of training. Lastly, we must find workable solutions to the problems of the clinical investigator and provide a suitable atmosphere in which he may work.

Even to those who persist in maintaining that good health is a right, it must have become apparent that it is financially impossible to supply the best that is available in medicine, in the most pleasant form, to all those who desire it. In addition, it must soon become apparent to the recipients of this care that they must begin to take better care of themselves.

It must be obvious that through medical science and technology there has developed a system of medicine which, when applied in the ultimate way, is far beyond our capability to pay for it. Although it undoubtedly would be pleasant, and at times even advisable, to provide special-duty nursing around the clock in intensive care units for all patients undergoing operation, it is obvious that it is totally impossible to supply such personnel and facilities. It is unlikely that we shall ever be able to countenance the replacement of all the hearts, lungs, kidneys and livers that fail, no matter how successful these techniques may become.

At some time, also, it will be necessary for responsible political officials to tell their constituents that along with their right to health goes the duty to do those things which promote their own health and that of others and to refrain from those practices which are detrimental. To speak more plainly, we will advance greatly when the people themselves determine that they will bring into the world only those children that they can care for, feed, and educate; when they will cease poisoning themselves and the atmosphere around them with tobacco and other pollutants; when they will cease the operation of destructive devices like motor vehicles when their abilities are impaired by intoxicants; when they will purchase clothing for themselves and children as much for the flame-resistant quality as the superficial beauty and when they will wholeheartedly and honestly throw themselves into the fight against disease and injury in at least as fervent a fashion as they expect of their physicians and surgeons.

Operating Room Efficiency

We, as practicing surgeons, must find solutions to the logistic problems which will permit more efficient use of operating rooms. The development of more efficient admission practices and more efficient programming of hospital stays should be used to reduce the waiting time for admission to hospitals for simple and uncomplicated surgical illnesses, like herniae, varicose veins and the like. In addition, we should consider methods for insuring the efficient utilization of surgeons which are superior to our present outdated plan of supply and demand. In some surgical areas there are unquestioned shortages of specialist trained personnel but in others there is a super abundance. This is particularly true in metropolitan areas.

Although the National Health Service of Great Britain suffers badly in our usual characterization, we must admit that at least in one area it is efficient. Consultants (that is surgical specialists) are not appointed until there is a need for them and those who are appointed are supplied from the day they finish their training with a sufficient number of patients to keep them busy earning their keep and, by the way, maintaining their professional skills at a very high level. In contrast, our system all too frequently prepares a young surgeon

by study in a very busy residency training program for entry into practice in the larger population centers where he finds that he has been relegated to a life of leisure, having been added to an already large group in crowded coffee rooms or lounges languishing in wait for someone to throw him a bone, a pile or a sebaceous cyst. At times, years pass in this way before a reasonably busy practice can be built, by which time much of the skill previously learned has been lost.

Standing in Line

We have advanced economically in the training of surgeons so that they are no longer penalized economically for the years of their training to the degree that was once true, and yet our practice of forcing our newer colleagues to stand in line for patients perpetuates a system resulting in high fees unlikely to be reduced as the surgeon's practice becomes more busy. Indeed, it is amusing to speculate on how few surgical operations are required at "usual and customary" fees for surgeons to support themselves in higher income brackets. In most instances doubling, tripling or quadrupling this output, which is well within the capability of the vigorous, skillful technician, simply means turning over a larger and larger amount of money to overhead and federal and state governments in income taxes. How much better it would seem if this money could be returned to the individual patient in the form of lower fees rather than in the form of tax relief after the money has passed inefficiently through the hands of federal and state governments.

In addition, there must be some thought given to the propriety of pouring a large segment of our research money and patient care effort into treating patients whose care will be the ultimate in cost while giving very little attention to improving and increasing the number of procedures done for the betterment of the average surgical patient. It will obviously be impossible to supply a new set of organs to every citizen of the United States who wears one out within the next decade. On the other hand, using the same facilities and the same money, it may well be possible to improve and increase the standard of surgical care for the average patient.

The marvelous science of medicine has combined with the bureaucratic practicalities of third party payment and the ease of dealing with patients in hospitals to promote and prolong hospital stay. This has led to unnecessary hospitalization for examinations which could less expensively have been carried out on an outpatient basis and to protracted hospitalization following illness because of patient and physician convenience. If the cost of medical and surgical practice is to be kept within bounds, we must increase the efficiency and utilization of outpatient facilities, except for those illnesses which absolutely require hospitalization. Furthermore, the efficiency with which patients are dealt, once they are admitted to the hospital, must be constantly reviewed and improved. Many attempts to provide this type of outpatient facility have come to naught because of arbitrary decisions by various legislative maneuverings which make these facilities illegal or else prevent the collection of insurance benefits which would have been paid for hospitalization though at a much greater cost.

Limitations Imposed

In the area of professional education we have advanced into an era which has seen many complicated limitations imposed by men of good political will and power who have acted as they have partly because of a seeming dearth of ideas from the medical and surgical leadership. These limitations and other social alterations have led to a basic dilemma which dictates a concerted effort to reduce the number of nonprivate surgical patients on the theory that it is undignified to be unable to afford private medical care and, on the other hand, strives to increase the number educated to become practicing physicians and surgeons. The public has come to expect that a private patient should be permitted to command the services of a surgeon who is already well trained and competent in his specialty. Unfortunately, surgeons are not instant successes and must perform their first operations on someone. Now one can hardly expect legislators to discuss this problem in open forum, for who among them would have the fortitude to explain the necessary details of surgical education to his constituents? The residency system which has worked well for many years would seem still to provide the best solution to the problem, but this relies to a great extent on the judgment of the surgeons in charge, their abilities and their willingness to teach. This is difficult to define through legislative process but, before further advances in surgical education may be achieved, all these problems must be placed in perspective which results in achieving understanding and cooperation in both federal and state governments with the smooth transition of a college student into a skilled, responsible, experienced surgeon by a method which permits high quality surgical care for the patients involved at a cost which is acceptable, using a payment plan which fits into the overall framework of medical payment in our country.

Research Must Continue

Future research in surgery and medicine in general must have some of the same give and take about it. It is obvious that research must continue in both the basic and applied areas but that neither should be

slighted in favor of the other. The real goal should be directed toward the eventual solution of man's problems and not research for research's sake. Once again, these problems must be solved with the understanding and cooperation of government. Care must be taken to provide balance, allowing sufficient security for the research laboratory but sufficient incentive to insure that it is productive. At all cost we must avoid some of the mistakes in the past few decades which have seen basic scientists go from underpaid and underfed preclinical nobodies to such overwhelming power and influence in medical school administrative affairs that research in nucleic acids has so overshadowed investigation of methods for the delivery of health care that there is currently evidence of a revolution which threatens to topple medical research in favor of any idea which purports to have social significance and direction.

Future advances in the solution of clinical research problems will be handicapped until there is a better understanding of the propriety of clinical research. It should be obvious that clinical research will take place whether or not informed consent is given by a group of patients; the only question is whether the analyses will be made prospectively or retrospectively. As new drugs and procedures become available they will be utilized, and the success or failure of the technics can be determined only by the results obtained in sufficiently large groups of patients. In favor of the prospective technic with controlled studies inherent in the method, a quicker and more sound scientific evaluation may be brought about with eventually less risk to the patients so treated. The only alternative is to try the methods which survive the basic scientific laboratory, keeping only those which allow patients to live, and discarding those which cause their death or increased disability. The latter procedure is inherently less sound.

In summary, surgery, aided immeasurably by gifts from the basic science laboratory, has advanced remarkably in the understanding and treatment of human illness. I predict that future improvements through technical advances will plateau and that the most fertile fields for the near future lie in the laboratory and in the improvement in the delivery of patient care. ◄

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Man and the Wart

T. D. ARLOOK, M.D.
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"The ways of warts are mysterious, and they sometimes disappear in a few days under methods of treatment at which in the days of one's youth one was inclined to scoff."
—Norman Walker

WARTS—verracae are benign, common, papillary growths appearing usually on the exposed surfaces of the skin, and are characterized by hypertrophy of the horny layer, in addition to increased length and irregularity of the papillae. Warts vary in size and in number. The commonest areas for the appearance of warts are the fingers, hands, face and soles. While warts may occur at any age they most frequently occur in children and young adults.

In the ano-genital area warts appear as acuminate fungating lesions. Plantar warts are similar to the common wart but because of the characteristic location on the plantar aspects of the foot usually overlying the metatarsal heads, or on the heel, they can produce disabling symptoms. They are frequently painful to touch and to walk on.

Etiology

Proof that a filtrable virus or viruses are the cause of warts is available in abundance. Warts have been inoculated in human beings, and Mendelson and Kligman[1] successfully cultured in tissue the virus causing warts. Walter and his coworkers[2] by means of fluorescent studies have confirmed the presence of the wart virus antigenic material in the nuclei of the upper prickle and granular cell layers. Typical common warts have been produced by intracutaneous injection of sterile wart filtrate. The incubation period is usually from one to eight months depending upon the susceptibility of the individual.

Diagnosis

"Ordinarily, your next door neighbor can diagnose warts as well as you can."—L. Goldman.

However, plantar warts must be differentiated from calluses and other rarer plantar hyperkeratoses such as corns, mosaic warts, radiodermatitis, Kaposi's sarcoma, granuloma pyogenicum, melanoma, arsenical keratoses and periungual elastosis. An aid to diagnosis of plantar warts is close examination of the growth after the surface is pared away with a sharp scalpel. This maneuver will expose the distinguishing features of these lesions which is a characteristic central core. On the pared surface freshly bleeding capillaries representing the capillary projections of a wart may be seen, or these vessels may be thrombosed, in which case the multiple brownish or black dots will be visible. In callosities there is no break in the normal capillary lines, and in corns, paring of the lesion exposes a central pearly gray cornified core without capillary vessels.

Morphologic Types of Warts

Pilsbury classifies warts into five morphologic types:

1. Ordinary sessile lesion (verruca vulgaris—the common wart) as seen on the extremities and especially on the fingers. These lesions are raised and have a rough gray surface.

2. Filiform warts—These are most commonly encountered on the face and neck.

3. Plantar warts—These warts on the sole are prevented by pressure from being elevated. These warts are as a rule painful when located on points of pressure. Palmar warts also can be present.

4. Flat warts—usually located on the face, forehead and chin—may resemble flat nevi. Most common in children.

5. Moist ano-genital warts—may also occur in any moist intertriginous areas and the verrucae tend to be exuberant and very autoinoculable.

Treatment

Warts occasionally involute spontaneously. Single warts often disappear after having been present for many weeks or months. Often older

warts may disappear and new warts may appear in other areas of the skin. How can such commonly observed phenomena be explained? One explanation is that warts have a "life-cycle," and the other explanation is that the host's (the patient's) defense mechanism in the form of antibodies is responsible for the disappearance of the warts. Each theory has proponents. Massing and Epstein's[3] work studied the natural history—the life cycle of warts—and reported they had seen many warts disappear without any therapy. Almeida[4] and his co-workers found antibodies in 50% of the warts studied. This evidence deserves repetition and expansion.

Warts are common skin infections caused by a small DNA virus. It is a capricious and unpredictable infectious disease.

A 15 to 20% recurrence can be expected regardless of the type of therapy.

The therapeutic procedures which I most commonly use and recommend include the following:

1. Under local anesthesia the wart can be removed with a sharp dermal curette. Light electrodessication of the base for hemostasis may then be used.

2. Liquid nitrogen or "dry ice." These freezing substances are placed on the wart until it has turned white for a few seconds. This method is rapid and requires no anesthesia, and is effective. The patient experiences a burning sensation that may last from a few minutes to an hour. Bullae usually form at the site of therapy. Repeated treatments may be necessary.

3. 20% podophyllin in tr. of benzoin is the treatment of choice for verruca acuminata. The medication is applied with an applicator to the lesion and must be washed off in 4 hours.

4. 40% salicylic acid plaster can be used in the treatment of plantar verrucae. A piece of this plaster the size of the wart is applied and held in place with adhesive tape. Leave tape on for 4 days, then remove it and with a sharp scalpel remove the dead material and reapply the tape. The use of these plasters is painless and convenient but slow.

5. Radiation. The use of ionizing radiation is not advisable.

6. Surgery. Surgical excision is not recommended.

7. Extreme care should be used in treating flat warts (verrucae plana juvenalis) of face, chin and forehead. Scars should never result in the ideal therapy of warts. Hence mild therapy only should be used in treating flat warts of the face. Application of liquid nitrogen for two seconds and the use of acne peeling lotions are often adequate.

8. With each treatment an appropriate prayer should be said in the hope that they will not recur.

Classification of Warts

Genetic Name	*Common Name*
Verruca vulgaris	Common wart
Verruca planae juvenalis	Juvenile flat wart
Verruca digitata	Digitate wart
Verruca filiform	Filiform wart
Verruca plantaris	Plantar wart
Verruca acuminata also known as (condyloma acuminatum)	Acuminate wart (the so-called venereal wart)

I wish to thank Dr. Sam J. Zakon for his helpful review of the paper.

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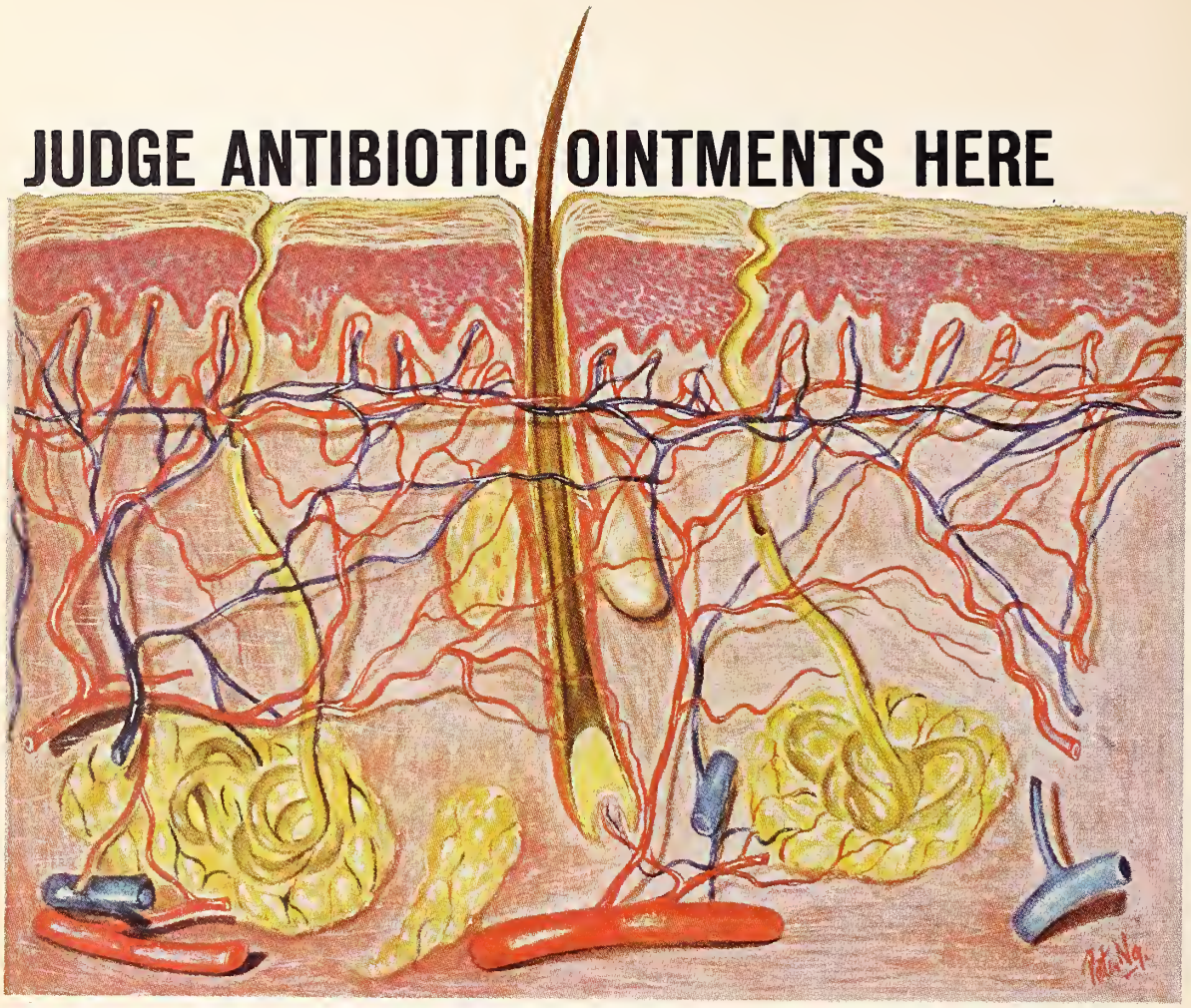
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Consommé	29	Tomato	69
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Chicken Gumbo	48	Cream of Chicken	76
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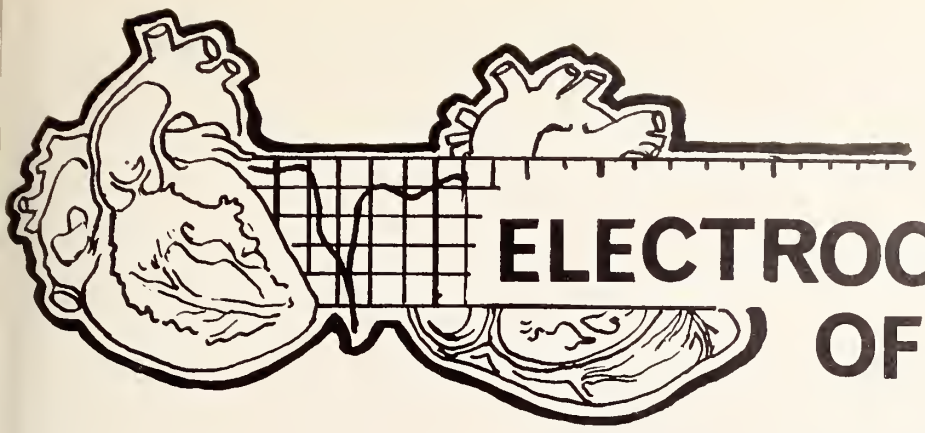
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ELECTROCARDIOGRAM OF THE MONTH

Ectopic Rhythms Due to Bradycardia in Myocardial Infarction

CHARLES FISCH, M.D.

*Indianapolis**

ONE of the serious complications of bradycardia attending acute myocardial infarction (M.I.) is the appearance of life-threatening ectopic rhythms. The accompanying figure is an example of such a complication.

The patient was seen at 5:30 a.m. with a classical story of M.I. on subsequent tracings. This was shown to be inferior in location. Lead I at 5:30 showed every third P wave to be dropped (3:2 S block). In leads III, AVL and AVF there was a marked sinus bradycardia with periods of sinus arrest. These were associated with ectopic ventricular escape beats or ventricular premature beats.

The tracing taken at 6:45 demonstrates an acute inferior infarction with complete AV dissociation.

The bradycardia responded promptly to intravenous administration of 1.25 mg. of atropine with disappearance of ventricular ectopic rhythms. ◄

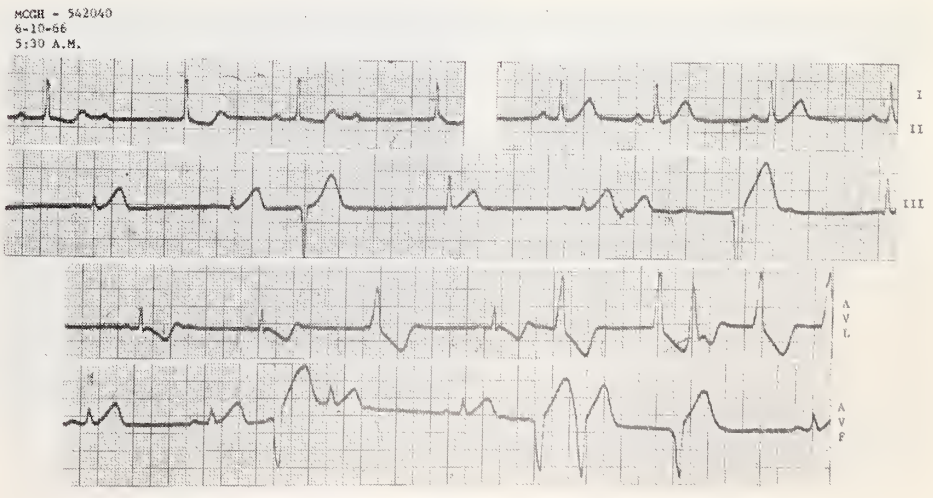


FIGURE 1

EARLY acute inferior myocardial infarction complicated by SA block and arrest and ectopic ventricular rhythms.

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.



X-RAY CONFERENCE

Arteriography in the Diagnosis of Osteogenic Sarcoma

*J. PAUL PETERS, M.D.**
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P. C., a 17-year old white male was admitted to the hospital in May 1970 with chief complaint of pain in the left arm and shoulder. The patient related a history of a sprain to the left shoulder while using a power saw some two months earlier. Shortly after this incident the shoulder became painful and, as time progressed, swelling developed.

Physical examination at the time of admission revealed a normally developed white male. The left shoulder appeared to be swollen; however, there was no turgor or increased temperature of the swollen joint. There was no significant motor or sensory deficit. The laboratory findings were unremarkable with the exception of roentgenograms that revealed a predominantly lytic lesion in the metaphysis of the left humerus. The lesion appeared to erode the epiphyseal plate but direct extension into the epiphyses was not appreci-



FIGURE 1

A selective left subclavian arteriogram demonstrates clusters of abnormal vessels with a typical palisade pattern and an osteolytic lesion involving the metaphysis of the left humerus. Extensive extension of the tumor into adjacent soft tissue is suggested by the arteriogram. A hypervascular stain in the posterior capsule, however, proved to be caused merely by inflammatory changes although the arteriogram erroneously suggests the possibility of tumor extension.

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ated. There was destruction of the cortex by this lytic lesion along the medial circumference of the humerus and a Codman triangle was formed by periosteal elevation. The lateral margin of the lesion showed a sclerotic pattern.

A selective left subclavian arteriogram demonstrated a hypervascular lesion involving the osseous structures associated with a huge soft tissue mass supplied by the same abnormal vessels. Abnormal vessels were also identified along the thoracic cage and appeared to fill by direct communication from the primary lesion. Abnormal vessels were likewise appreciated along the lateral circumference of the humerus indicating extension of the lesion through the periosteum.

A forequarter amputation was carried out. The primary lesion was identified as a classical osteogenic sarcoma and measured 8 x 5½ cm. The osteogenic sarcoma appeared to extend directly into the head of the humerus involving the epiphyseal plate. It had broken through the cortex along the medial circumference and invaded the soft tissue. However, on the opposite side, as suggested by the arteriogram, neoplasm emerged through the periosteum. The lining of the posterior capsule near the glenoid, that likewise demonstrated a hypervascular pattern, was examined on separate histologic blocks and revealed only chronic inflamation. No tumor could be identified in those sections.

Discussion

The value of arteriographic assessment of a primary bone tumor is exemplified by this patient. Unsuspected marked soft tissue involvement by the tumor was readily demonstrated on the arteriogram. However, it is also emphasized that the arteriogram was misleading to a degree, as it appeared to indicate tumor extension in the area of the capsule in the subglenoid region on basis of a hypervascular pattern which was proven on histologic section to merely represent inflammatory changes.

The efficacy of this modality for delivery of chemotherapeutic agents to the tumor-bearing area is likewise emphasized. ◄

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Carbenicillin has greater activity against E. coli, Proteus mirabilis, and most gram positive organisms, but offers no advantages over the older antibiotics against most of these strains. It does seem to offer an improvement over ampicillin against proteus-strains other than Proteus mirabilis and is effective against many strains of E. coli resistant to ampicillin. Strains of Klebsiella are largely resistant to carbenicillin as are all strains of staphylococci resistant to penicillin G and most strains of Serratia.

For serious systemic pseudomonas or proteus infections, 40 grams of carbenicillin per day is often required given as 5 grams intravenously over a 30-minute period every 3 hours. For serious urinary tract infections, 200 mg per Kg. per day may be required. Smaller doses may be effective in less serious urinary tract infections since very high urinary levels are easily obtained with smaller doses.

Several disadvantages of carbenicillin are already evident. At 40 grams per day the estimated cost to the hospital will be $100 a day. In hospitals where carbenicillin has been used extensively, many pseudomonas strains have been isolated which are highly resistant to carbenicillin. Carbenicillin does give allergic reactions similar to penicillin G and must be used very cautiously, if at all, in patients allergic to penicillin G. Finally, in patients with renal damage, the dose of carbenicillin must be reduced to avoid toxicity with the extremely high serum levels which would otherwise be obtained.

Today, this drug does not seem to be the answer to our increasing problem with pseudomonas diseases but seems a lead to newer penicillins which might be more effective against some of our problem infections. ◄

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Three Constitutional Amendments Proposed

HOOSIER voters, next month, will vote on three amendments to the Indiana State Constitution.

Three issues will be presented—the length and frequency of legislative sessions, the selection of state judges and the length of terms of three state officials.

One amendment would permit the General Assembly to meet in annual sessions, but does not require it to do so. The provision states that session length and frequency may be set by law. Now the Assembly is restricted to 61 calendar days in regular session and 40 calendar days in special session. The amendment would also remove the restriction on the special session length.

Even with the amendment, special sessions would continue to be convened only upon the call of the Governor; however, as is now provided, the Governor would not be able to limit the agenda of extraordinary sessions.

The amendment also provides that, until the Assembly passes a law to establish the length of sessions and their frequency, any regular session will be limited to 61 *working* days and may be recessed for any period of time not to exceed 21 days for committee work. Also the amendment would not allow a regular session to extend beyond the 30th of April of the year in which it was convened.

The judicial amendment would provide for the appointment of judges for the Supreme Court and the Appellate Court by the Governor from nominees proposed by a nominating commission. After two years in office each judge would be subject to a referendum by the voters, after which, if successful, he would serve for 10 years. The judicial nominating commission would also serve to recommend retirement of judges for disability or misconduct.

The amendment would also set up several district appellate courts, each with three judges. The Supreme Court would have a Chief Justice and could vary in size from 5 to 9 members. Prosecuting Attorneys would be required to be attorneys. References to Justices of the Peace would be removed from the Constitution, making that office subject to regulation by statute.

The third amendment would increase the terms of office of the Secretary, Auditor and Treasurer of State from two to four years, thus making four-year terms for all state officers except the Superintendent of Public Instruction.

The amendments have been approved by the last two Legislatures and, if approved by the voters, will become effective.

These and other amendments to be considered in the future are the direct result of work by the Constitutional Revision Commission which was formed by the 1967 Legislature. Seven amendments were approved for the first time in 1969 and, if approved in 1971, will be the subjects of referendum in the general election next following the legislative action.

The Constitutional Revision Commission, under the chairmanship of former Governors Matthew Welsh and Harold Handley, is continuing its modernizing mission and is now working on recommendations for the 1971 Legislature.

The present Constitution was adopted in 1851—119 years ago. Even the most conservative traditionalist will have to admit that some improvements and modifications are necessary. Rewriting of the entire document by a Constitutional Convention has been considered but not recommended. The gradual change by amendment is now in process.

Workmen's Compensation Most Effective

WORKMEN'S compensation insurance is the most effective system of social insurance in America today. Despite the fact that it is ruled by state laws, no two of which are alike, it has developed into a powerful force for protection and rehabilitation of the worker.

The compensation system is underwritten both by private insurance companies and, in some cases, by state funds. Competition has provided many improvements since the days when dollar benefits to the injured worker were the main consideration. Safety engineering, accident prevention, improvements in benefits, better medical care and increasing emphasis on rehabilitation and return to the job and full production have improved the worker's physical, psychological and financial well-being.

Despite these many advantages, the system does, however, suffer with weaknesses. These are recognized by the compensation insurance industry and, as expressed publicly by Clarance G. Johnson of the Industrial Indemnity Company, the industry is analyzing the deficiencies and seeking corrective action.

Mr. Johnson points out that medical payments are limited in some states and also, in some states, payments have not kept up with the cost of living. Eligibility varies from state to state and many state programs do not provide for occupational disease. There are some states in which rehabilitation is not practiced or not adequately followed up. In some jurisdictions the system is so legalistic that litigation is encouraged.

The fact that these variations are created by state laws has suggested that the cure should be the federalization of the entire system. The addition to Social Security of benefits for disabled workers and the liberalization of these provisions furnishes an entry in this direction.

Disadvantages of the Social Security mechanism consist of its slow and rigid method of paying benefits. It does not provide safety services or injury prevention, it does not provide medical care and it totally lacks any incentive or means of rehabilitation. As a matter of fact, the federal program encourages invalidism and dependency.

All these considerations are understandably and justifiably the concern of the compensation insurance industry, whose many organizations have, as a result of free competition, built up a magnificent system for the protection and comfort of the sick or injured worker. Their desire is to improve the present mechanism and to preserve its humane attitudes with an interest in rehabilitation.

Guest Editorials

Safety Bill Would Do More Harm Than Good

WHAT employer doesn't want his workers to be safe in their jobs?

The health and safety of employees has been a matter of utmost concern for employers for many years. The reasons are obvious.

There's the human element. No employer who has seen one of his workers injured ever wants it to happen again.

And it's good business. Accident prevention promotes efficiency, cuts costs, boosts profit potential.

The record has been good. With many millions of dollars spent for research, progress has been steady. Today the average American is safer at his job than he is at home, on the highway or at play.

Even so, the search for improvement must go forward. The National Chamber federation has supported legislation that would give the states incentives to develop better safety plans and, in President Nixon's words, would channel "power, funds and authority . . . increasingly to those governments that are closest to the people."

But any legislation, in addition to being effective, must also be fair.

Unfortunately, a measure, by Chairman Dominick V. Daniels (D-N.J.) of the House Select Labor Subcommittee, could—if enacted—be one of the most disruptive of sound labor relations ever proposed.

It would allow employees to strike and receive full pay—even if no safety standards have been violated!

The bill would require employers to keep paying employees who walk off the job on the grounds they haven't been given the necessary safety equipment or sufficient information about a "potentially toxic substance."

Again, complete authority to *set* standards, to *police* them, and to *enforce* them would be lodged in one man—the Secretary of Labor.

Only the courts should have the power to shut down a business.

Unfair measures like the Daniels' bill would, if they became law, undermine much of the progress that has been made in the safety field.**—Arch N. Booth, Executive Vice President, Chamber of Commerce of the United States, Washington, D.C.**

A Legacy From Those Over 30

Editor's Note: The following editorial was originally published in the *St. Louis County Medical Bulletin* and was reprinted in *Missouri Medicine*.

THE much-maligned older generations got their due from the president of Penn State, Eric A. Walker, in a speech to last summer's graduating class.

"If you of the graduating class will look over into the bleachers to your left or right, I would like to introduce you to representatives of some

of the most remarkable people ever to walk on earth. These are people you already know—your parents and grandparents. And remarkable people they are indeed.

"Not long ago an educator from Northwestern University by the name of Bergen Evans got together some facts about these two generations—your parents and grandparents. I'd like to share some of these facts with you.

"These are the people who have given you a healthier world than they found. And because of this you no longer have to fear epidemics of flu, typhus, diphtheria, smallpox, scarlet fever, measles or mumps. And the dreaded polio is no longer a medical factor, while TB is almost unheard of.

"Let me remind you that these remarkable people lived through history's greatest depression. Many of these people know what it is to be poor, what it is to be hungry and cold. And because of this, they determined that it would not happen to you, that you would have a better life, you would have food to eat, milk to drink, vitamins to nourish you, a warm home, better schools and greater opportunities to succeed.

"Because they gave you the best, you are the tallest, healthiest, brightest, and probably the best looking generation to inhabit the land.

"Because they were materialistic, you will work fewer hours, learn more, have more leisure time, travel to more distant places, and have more of a chance to follow your life's ambition.

"These are also the people who fought man's greatest war. They are the people who defeated the tyranny of Hitler, and who when it was all over had the compassion to spend billions of dollars to help their former enemies rebuild their homelands. They had the sense to begin the United Nations.

"They built thousands of high schools, trained and hired tens of thousands of better teachers, at the same time made higher education a real possibility for millions of youngsters—where once it was only the dream of the wealthy few.

"They made a start—although a late one—in healing the scars of the earth, in fighting pollution and the destruction of our natural environment. They set into motion new laws giving conservation new meaning, setting aside land for you and your children to enjoy for generations to come.

"They also hold the dubious record for paying taxes—although you will probably exceed them in this.

"While they have done all these things, they have had some failures. They have not yet found an alternative for war, nor for racial hatred. Perhaps you will perfect the social mechanisms by which all men may follow their ambitions without the threat of force—so that the earth will no longer need police to enforce the laws, nor armies to prevent some men from trespassing against others.

"They made more progress by the sweat of their brows than in any previous era—don't forget it. If your generation can make as much progress in as many areas as these two generations have, you should be able to solve a good many of the earth's remaining ills.

"It is my hope, and I know the hope of these two generations that you find the answers to many of these problems that plague mankind.

"It won't be easy. You won't do it by negative thoughts, by tearing down or belittling. You may and can do it by hard work, humility, hope and faith in mankind. Try it."

Professional Free Loading

WHILE MOST physicians carry hospitalization insurance, relatively few have policies to cover the cost of physicians' fees. Few physicians ever pay for medical care for themselves or their immediate families and Blue Shield coverage for them is, they feel, a waste of money.

The tradition that physicians are entitled to medical care from their colleagues without pay is an ancient one. While a plumber can unclog the pipes in his own home and generally doesn't require the services of another plumber, physicans don't usually treat members of their own family, and they do need the services of another physician. Before the days of widespread specialization, one general practitioner would exchange his services for those of a fellow GP when their respective families became ill. This was called professional courtesy, and since cash money was frequently scarce in many communities, the system was a good one.

In lieu of exchanging fees, each physician would later express his appreciation for the services of his colleague by a token gift on some appropriate occasion.

With the evolution of current patterns of medical practice, however, the entire system of "professional courtesy" has become less than satisfactory. Some time ago, the AMA Judicial Council attempted to deal with medical freeloading with the ambiguous concession that it was ethical for a physician to accept a fee from a colleague for his services. This meant that each physician had to figure out whether his professional patient was really insisting on making payment or merely going through the motions that would relieve him of his own embarrassment with the situation.

In this day of almost universal medical affluence, the time has come to quit playing this game of musical chairs in treating the family of fellow professionals. Certainly, most physicians can afford medical care for their families as readily as most of their patients. The basic reason for "professional courtesy" no longer exists, and its tender has become more

of a nuisance than an expression of graciousness.

In localities where there are large numbers of young physicians, the amount of time devoted to nonpaying patients, particularly by obstetricians, pediatricians, and psychiatrists, is often substantial. The younger men, with growing families, unintentionally represent a considerable drain on the popular physicians in the community. These physicians should be better compensated for their time than with a doubtful collection of gift merchandise at Christmas time.

There is no reason why physicians and their families shouldn't be charged for medical services as other patients are charged. As other patients carry insurance protecting them against medical costs, physicians should similarly add to their insurance coverage. In both the short-term and the long-run, the abolition of "professional courtesy" in the exchange of medical services and the substitution of compensation for service will be to the advantage of both the giver and receiver of medical service. The former will receive the income he deserves for his service, and the latter can approach his colleagues for service without feeling that he is imposing on his time and generosity.

As an increasing number of professionals come into the health-care field, the old practice of "professional courtesy" becomes less and less practical. It is time to consider ending it. We must treat all our patients alike—whether they are the families of professional friends or total strangers. As physicians we would be well advised to subscribe to medical-care insurance that would enable us to pay our colleagues as we would like our colleagues to pay us.

It is to be hoped that medical organizations at the community, state, and national levels confront the problem and establish a uniform standard. But if they don't—at least immediately—each physician should stand up in his own dignity and refuse to continue to be a charity case on his friends—D.N.G. *Wisconsin Medical Journal* 69:30-31, May 1970. **Reprinted with permission.**

Editorial Notes . . .

Bees, wasps, hornets and yellow jackets cause more deaths in this country than do snakes. Two out of every five deaths caused by venomous bites are caused by these stingers. A past history of allergy to stings is not necessary, one sting may be fatal. The Health Insurance Institute advises that all reactions to stings that are in excess of local swelling should be investigated carefully. Desensitization may be indicated.

Cincinnati will soon have two automated multiphasic health testing facilities. Clinical Computer Corporation of Cincinnati and Searle Medidata (subsidiary of G. D. Searle pharmaceutical), will establish the computers, which will record results from 55 tests on patients, including medical history, hematology, blood chemistries, urinalysis, x-ray, spirometry, Pap smear and breast examination, cardiovascular and eye and ear evaluation, all at a fraction of the usual cost. Only a few technicians are needed to test thousands of patients each year. The information is forwarded to the patients' physicians. The entire test can be completed in about 90 minutes.

Scleroderma now has its voluntary organization—The Sonya Shapiro Memorial Foundation for Systemic Scleroderma. It is devoted to the pursuit of education and research into the causes and treatment. It will serve as a clearing house for all discoveries and areas of interest.

The "New York Times" reports that the Chinese communists criticize the China Medical College by charging that: The training program is too long; students are not assigned for training in rural areas; students from working class and peasant families are discriminated against; there is too much emphasis on grades and examinations; students have no time for political activity and do not participate in physical labor. Sound familiar?

Intensive care beds were doubled during the past year by the Veterans Administration. Forty-five intensive care units with 634 beds were built or improved during the past 12 months. Nineteen additional units are planned for the next year. The VA finds this type of care to be more effective for critically ill patients than individual attention by special nurses.

Medical advances are not only creating more fire hazards in hospitals but are also making it more difficult to protect the patients and evacuate them when threatened by fire. Disposable items are more combustible than those which they replaced. The use of oxygen, sometimes under pressure, has increased. Patients are older and less vigorous than formerly and when under intensive care are tubed and wired so as to be almost immovable. Dr. William Dornette of Cincinnati and Donald Yuellig, marshal of the Cincinnati Fire Department, report on the problem to the National Fire Protection Association and urge the maximum amount of care and vigilance.

The 60th anniversary of his internship at St. Mary's Hospital of Evansville was marked recently by the dedication of the Herman M. Baker Medical Library in that institution. Although Dr. Baker has retired from private practice, he will devote his time to the teaching staff of St. Mary's in connection with its function as a teaching hospital of Indiana University Medical Center. The Rehabilitation Center of Evansville, in which Dr. Baker has been very active, will also receive his attention. ◄

The Woman's Auxiliary

REPORTS TO ISMA

Summer is gone and fall is in the air and it gives one a nostalgic feeling. It would be fun to dream and drink in the beauties of fall. But who has the time? Certainly not the Auxiliary members. Fall is our busiest time.

We had our State Workshop in Indianapolis the 23rd of September at which Dr. Otis Bowen was our luncheon speaker and of course that was a special day for us all.



October will be even busier, with the National Conference for Presidents and Presidents-Elect from all fifty states gathering with the National Officers and Chairmen in Chicago to exchange information new and old to help further the Auxiliaries' aims. This conference will overlap with your Indiana State Medical Association meeting in South Bend. The program for the women sounds very exciting, especially with Gwen Stiver at the wheel. Also, there are interesting programs for the men that the women may enjoy.

Following the ISMA convention, with another overlap, will be the North Central Regional Workshop in Chicago. This is also attended by the national auxiliary officers and chairmen. From our state will be myself, Lelia Chernish, our President-Elect, and four key chairmen for this year. Leona Brown, our AMA-ERF chairman; Jo Davidson, our Health Careers Chairman, Pat Gootee, our Community Service Chairman, and Ruth Gattman, our Legislative Chairman. With such good representation for our State we hope to come back home full of knowledge to share with you all.

On my travels this fall I will have the advantage of seeing Indiana from one end to the other and will be able to really appreciate our wonderful Hoosier State.

Here's hoping we see a great many of our Auxiliary members at the Workshop and especially at South Bend convention, because you men can have fun showing your wife off to other Doctors from all over the state. See you there.

Doris M. Clouse

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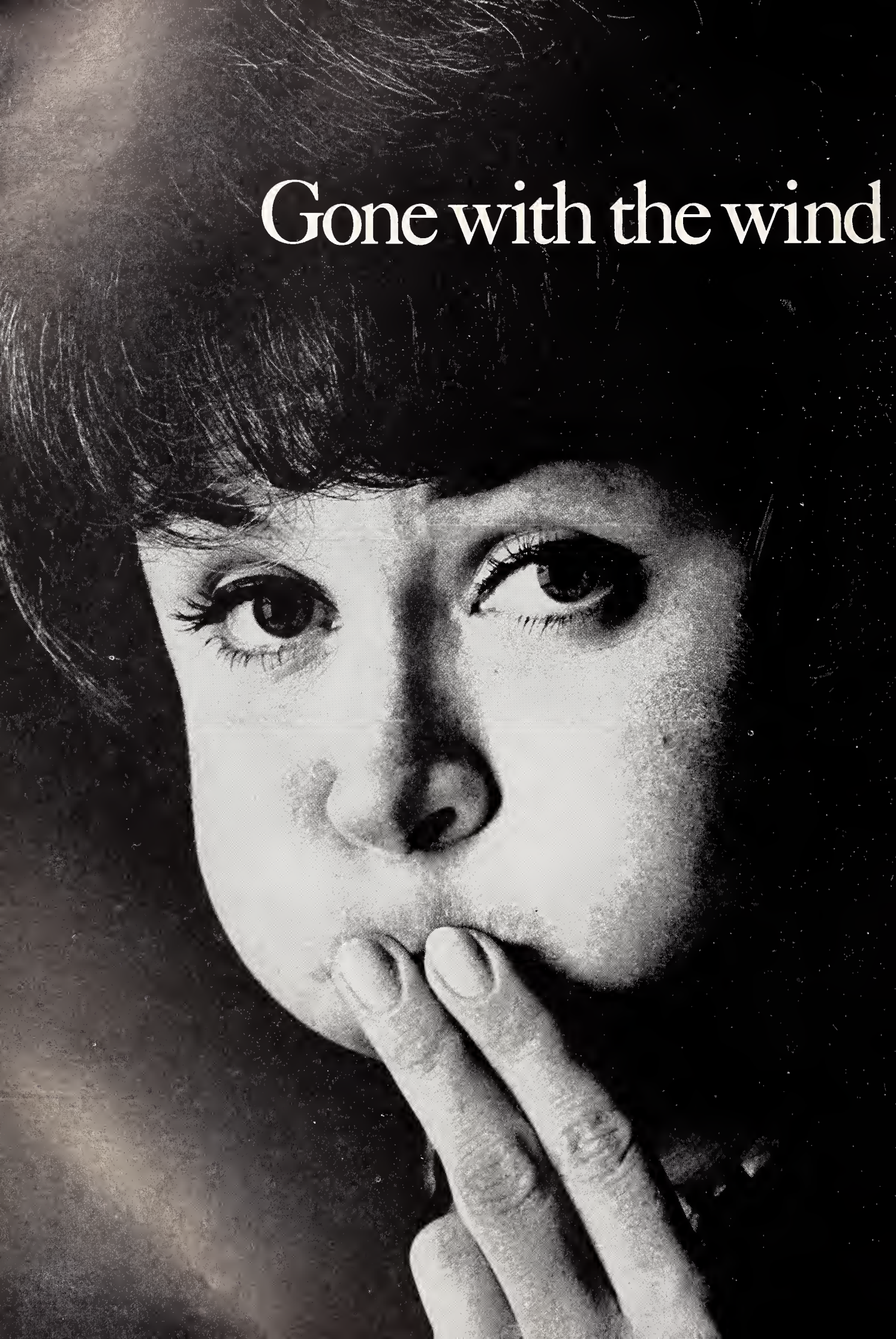
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*Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

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The Southside Community Health Center

JOE RAMSDELL*

In the spring of 1968 a group of medical students, moved by idealism and impatient with the years of training that lay between them and service to society, joined with members of an inner city community in need of a local source of health care and anxious to participate in its organization and operation. The result of this union was the Southside Community Health Center, Inc., at 234 West Morris, on the near southside of Indianapolis.

The clinic was built on three basic principles. First and foremost, was community control over all non-medical policies of the clinic, control being exercised through an elected board of directors. The second principle was the use of third and fourth year medical students, in their clinical years, as the primary clinicians of the clinic. This followed the model of the outpatient clinics at the university hospitals with the students consulting with a senior physician on their individual patients. The third principle, and perhaps the most unusual aspect of this clinic, was the use of first and second year students as health advocates who would go into the community to serve as a liaison between the patients and the often awesomely complex world of medical bureaucracy. The health advocates would also serve as teachers of the basic principles of family health.

The students, working as an *ad hoc* committee associated with the Student American Medical Association, and representatives from the Southside Community Council, Mayer Missions Settlement House, and Concord Settlement House, organized a board of directors which was to oversee and direct the operations of the clinic. The board was elected at a general community meeting in October 1968. At a subsequent meeting of the board, officers were elected and application was made for status as a tax exempt, non-profit organization.

The building for the clinic, a two story frame house located on West Morris Street in the heart of the community served by the clinic, was donated by Mayer Presbyterian Church. The first floor of the building was renovated and remodeled by medical students and community people and yielded four examining rooms, a laboratory, a waiting room and a receptionist area.

The clinic was officially opened on January 26, 1969. The open house was attended by the Dean of the Indiana University School of Medicine, the mayor of Indianapolis, and faculty and staff of the School of Medicine, as well as interested physicians, students and members of the community.

From its beginning, the project enjoyed the support and approval of the administration of the Indiana University School of Medicine. This support was moral and tangible (in the form of equipment for the clinic). The Marion County Medical Society gave its approval to the project following a meeting of clinic organizers with its executive council. The clinic has also enjoyed the support of many members of the Indiana State Medical Association.

The Community

The area served contained a population of 9,000 with a median income in 1960 of less than $5,000 per family. Much of the housing was substandard with 55 to 78% of the housing units listed as deteriorating or dilapidated in the 1960 census.

One practicing physician had his office within the community. However, his practice was drawn primarily from outside the neighborhood. As a result, the majority of the community's medical care was provided by the Marion County General Hospital MCGH was a recent innovation, Although bus transportation to MCGH was a recent innovation, most of the people still deferred the use of the hospital except in emergency situations. The community had indicated a strong desire for a health clinic prior to this project. Plans for such a clinic were formulated in 1967 using Community Action Against Poverty funds, and the community was extensively surveyed and its needs statistically tabulated at that time. This project, however, did not come to fruition, leaving the community sadly disappointed.

The Clinic

The clinic was organized with the goal of practicing general medicine with an eye to reducing the episodic and emergency oriented medical habits of its patients. It is open three nights a week from six to ten on Monday, Wednesday and Friday evenings. The clinic staff, all voluntary, includes four junior or senior medical students as clinicians, two staff men who are licensed to prac-

* Student, Indiana University School of Medicine, Indianapolis 46202.

tice medicine in the state of Indiana (these are primarily drawn from the Indiana University School of Medicine), registered nurses, a medical technician, a pharmacist and a receptionist. These individuals are supervised by a clinic coordinator who is a junior or senior medical student responsible for the smooth operation of the clinic.

From 75 to 90 patients a week are seen presenting the students with most of the common medical, pediatric and gynecologic problems familiar to general practice. These problems include episodic illnesses such as acute otitis, upper respiratory infections, vaginal discharges, etc. Patients with more chronic problems are also followed, often under the care of an individual senior medical student who supervises a patient's care for one year. Included in this group are such problems as hypertension, diabetes mellitus, congestive heart failure, obesity, psychological problems, etc. Patients requiring specialized or complicated evaluation are referred to another medical facility, usually MCGH. Many of these patients are referred back to the Southside Community Health Center for follow-up care. In cooperation with the Department of Obstetrics and Gynecology at the School of Medicine, an Ob-Gyn prenatal clinic is held once a month which is staffed by members of that department and provides services ranging from prenatal care to diagnostic evaluation of female problems.

The recently remodeled upstairs contains a dental clinic with five chairs, which is to be supervised and operated by students and faculty from the School of Dentistry of Indiana University. This dental program was instituted as another phase in the clinic's efforts to provide comprehensive health care at the health facility.

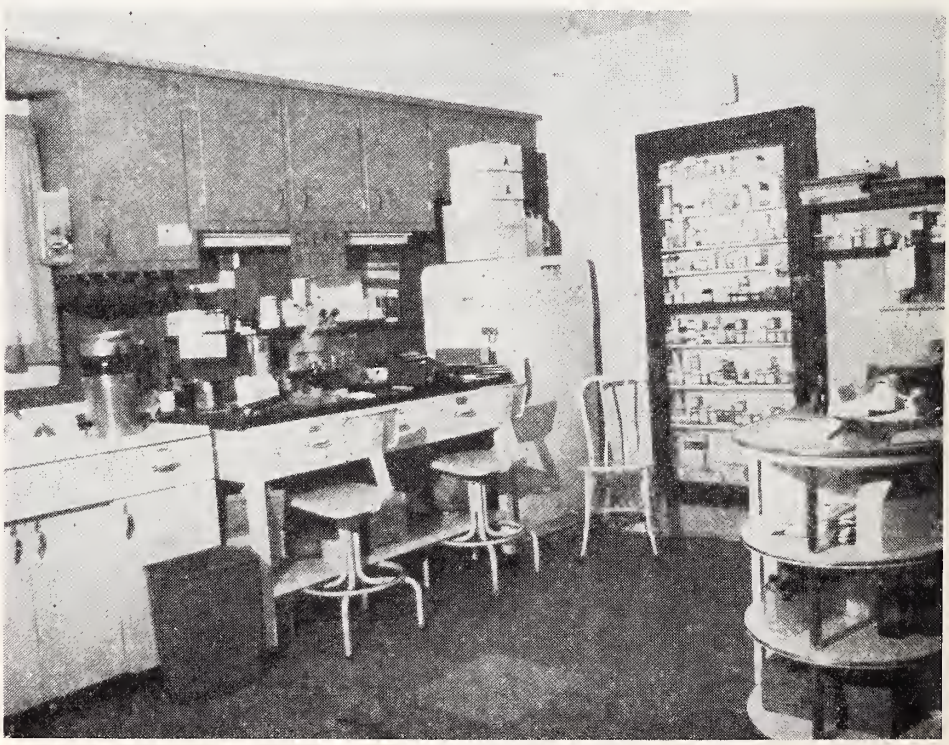
Preventive medicine is practiced in the form of physical examinations for jobs, routine check ups, infant immunizations, routine Pap smears and birth control advice. There is a coordinated effort with the various neighborhood agencies, including public health nursing clinics, social work agencies and settlement houses, to encourage full use of the clinic's preventive medicine potential. The students who serve as health advocates rely heavily on these agencies in solving the socio-economic problems they encounter.

Medications necessary for patient care are available free of additional charge at the clinic's formulary which is stocked primarily by donations from many of the major pharmaceutical houses. Chemical analysis equipment allows the clinic to perform over 12 serum chemistries and serum hemoglobins. A microscope and a microcentrifuge complete the clinic's laboratory. The microbiology department of the Medical Center and the MCGH Pathological Laboratories have cooperated closely with the clinic, providing materials and performing tests which are beyond the clinic's limitations—such as cytology and bacteriology, etc. Urinalysis materials, blood screens, glucose tolerance and diabetic materials are available in the clinic laboratory.

The health center operates on monies received from clinic fees (50 cents a visit) and donations from various groups and individuals. Fund raising drives are held at irregular intervals as specific expenses arise. Recent remodeling, which resulted in the upstairs dental clinic and the addition of a fifth examining room, were financed by grants.

Health Advocates

The first and second year student may share in the responsibility for providing the community with comprehensive health care through the health advocate program. As an advocate, he is a health advisor who visits the home and becomes a concerned and committed member of the "neighborhood family." The student becomes familiar with the resources available in this city for



The laboratory at the Southside Community Health Clinic, Indianapolis.

coping with socio-economic problems. He often joins the family when they visit the clinic and takes pains to see that the recommendations for treatment are followed. In emergency situations, the Health Advocate assists the family in securing rapid medical assistance. Drawing upon various resources available at the clinic, he also attempts to assist in any legal or financial problems encountered by the family.

The Board

The Board of Directors is made up of 20 people elected from the community at large who are joined by eight medical students and two members of the Indiana University School of Medicine faculty. With the opening of the dental clinic, the Board has been expanded to include representatives from the School of Dentistry. Also present at Board meetings are representatives of the clinic nurses, Mayer Missions and Concord Settlement House. The Board is the governing body for the clinic with responsibility for setting all non-medical policy.

Results

After more than 18 months of continuous operation, the clinic has been well received by members of the community. The clinic has charts on over 1,300 patients and sees between 25 and 30 patients a night. The response of physicians, student clinicians, advocates and allied health personnel has also been gratifying. Staff physician support continues to grow and, by virtue of drawing upon the Medical Center faculty, the clinic is able to offer some of the most qualified consultants in the state to its patients.

The clinic has come to serve as a center for continued and expanding health service for the near southside, and working in close cooperation with MCGH serves as a model for decentralized health care in lower income areas. It also serves to expose the student clinician to aspects of medicine not commonly taught in conventional curricula, including the problems, health and otherwise, of a segment of society with which he may be unfamiliar. He is also introduced to the challenges of the practice of family medicine in a non-hospital setting.

Thoughts on the Clinic

Now, more than two years after its conception, the fusion of the students' idealism with the needs and experience of the community has resulted in a vigorous expanding center for health delivery in the heart of this neighborhood. Working closely together in a spirit of mutual respect, the community and medical personnel have demonstrated the desirability of community participation and control, where feasible for such a health facility, and in so doing have not only moved to meet the health needs of this community but have served to create a model for similar neighborhoods—the model of a neighborhood health center cooperating with community hospitals and controlled by the people it serves. ◄

Letters

to the editor

To the Editor:

It is my pleasure to announce the second winner of the Gordon Medical Scholarship Program (see *American Medical News*, Dec. 1, 1969, p. 3, and April 20, 1970, p. 6; *Modern Medicine*, Dec. 15, 1969, p. 64, and June 1, 1970, p. 175; *Rocky Mountain Medical Journal*, Dec. 1969, p. 4; *Medical Annals of the District of Columbia*, Jan. 1970, p. 68, and May 1970, p. 284; *North Carolina Medical Journal*, Dec. 1969, p. 502).

Robert Petrusky of Linwood, N.J., has been chosen the recipient of the 1970 Dr. Benjamin Lee and Dorothy Gordon Memorial Scholarship. Mr. Petrusky, a Phi Beta Kappa graduate of Rutgers, has received $5,000 to attend the Medical School of the University of California at Los Angeles. This has been awarded by the Scholarship Committee of the Atlantic County Medical Society.

The Dr. Benjamin Lee and Dorothy Gordon Memorial Scholarship has been donated by the undersigned and has been used as a model to encourage physicians to donate similar $5,000 scholarships through their County Medical Society to enable worthy local premedical students to attend medical school.

The first winner of the Gordon Medical Scholarship Program was Nicholas P. Lang. His scholarship was donated by Dr. Anderson Nettleship and Dr. Mae Banwell Nettleship. Mr. Lang is now attending the Medical School of the University of Arkansas.

I am most interested in hearing from anyone who would like to contribute a $5,000 medical scholarship to one of their local premedical students through their local medical society.

Sincerely yours,
MAURICE B. GORDON, M.D.
Ventnor, N. J.

His makeup is unique by tradition.

His ulcer treatment is unique by tradition, too.

In the world of entertainment, a clown's makeup remains the exclusive property of its originator. Time has established that tradition. In the treatment of ulcers and other gastrointestinal complaints, time has established Pro-Banthine as a tradition too.

Few drugs can boast a longer successful run. Introduced 17 years ago, this drug is a veteran gastrointestinal performer.

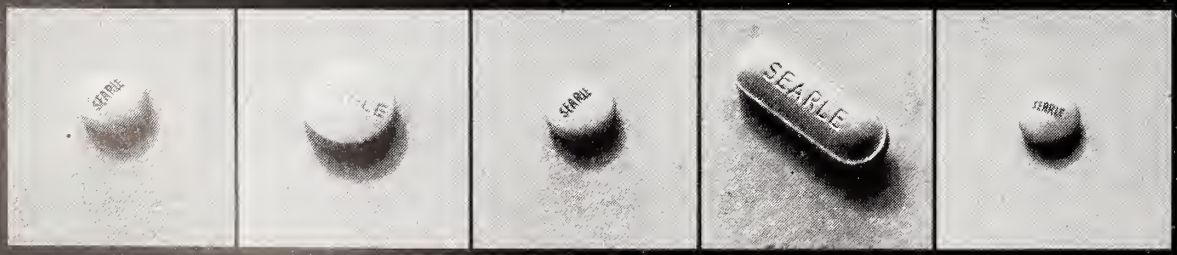
Pro-Banthine stars in the treatment of peptic ulcer, functional gastrointestinal disturbances, ulcerative colitis, hypertrophic gastritis, pylorospasm, acute and chronic pancreatitis, diverticulitis, biliary dyskinesia, hyperhidrosis, ileostomies, and colonic, ureteral or urinary bladder spasm. Its fame as an anticholinergic is worldwide.

When you want a performer you can count on . . . remember Pro-Banthine. Tradition does.

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Pro·Banthine®
(propantheline bromide)

the traditional ulcer treatment



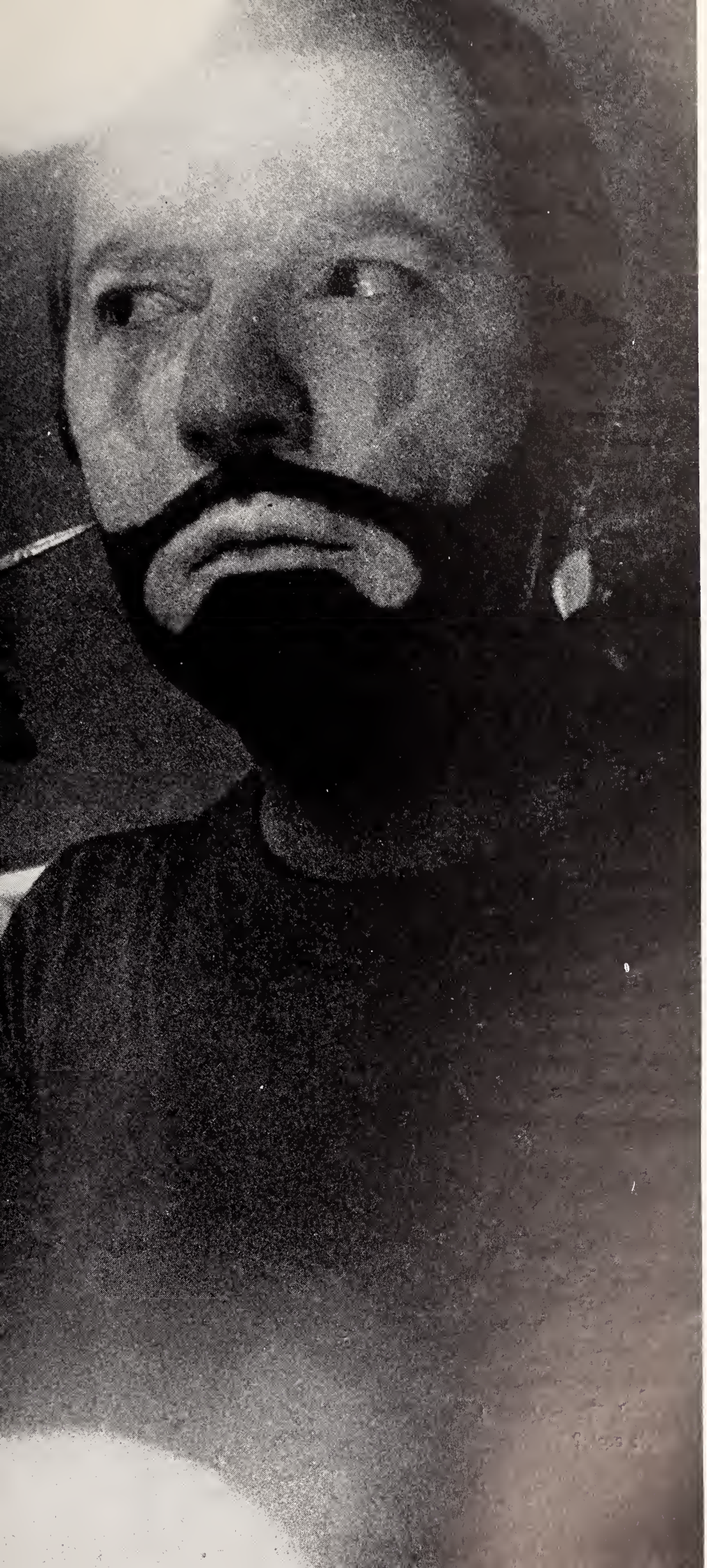
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Pro-Banthine 15 mg.
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with
Dartal 5 mg.
thiopropazate
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Pro-Banthine 15 mg.
propantheline bromide
with
Phenobarbital 15 mg.
warning:
may be habit forming

Pro-Banthine P.A. 30 mg.
propantheline bromide
in time-release form

Pro-Banthine 7½ mg.
propantheline bromide
Half Strength



Pro-Banthine®
(propantheline bromide)

Indications: Peptic ulcer, gastroenteritis, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.

Contraindications: Glaucoma, severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

Pro-Banthine® 15 mg.
(propantheline bromide)
with
Dartal® 5 mg.
(thiopropazate dihydrochloride)

Indications: Peptic ulcer, spastic constipation, nonspecific gastritis, functional gastrointestinal disorders, pylorospasm, hyperhidrosis, irritable bowel syndrome, mucous or ulcerative colitis, functional diarrhea.

Contraindications: Glaucoma, severe cardiac disease.

Warnings: Pro-Banthine with Dartal should not be administered to patients who are under the influence of barbiturates, alcohol or narcotics. The drug should be administered cautiously to epileptic patients or those in depressed states, patients with liver disease and to pregnant women. Hypersensitivity to Dartal may occur rarely in patients with known sensitivity to similar drugs.

Side Effects: Dryness of the mouth, mydriasis, hesitancy of urination; less commonly extrapyramidal (restlessness, dystonia and signs of pseudoparkinsonism such as muscular rigidity, fixed facies, tremor, ataxia, festinant gait and drooling), parasympatholytic (blurred vision, xerostomia, hypotension, nasal congestion and constipation) and curare-like (loss of control of voluntary muscles, particularly the muscles of respiration) reactions. Rarely, leukopenia or allergic purpura. A generalized erythematous skin reaction may occur. Side effects characteristic of phenothiazines such as grand mal convulsions, altered cerebrospinal proteins, cerebral edema, potentiation of the effects of atropine, heat or phosphorus insecticides, autonomic reactions, endocrine disturbances, reversed epinephrine effect, hyperpyrexia or pigmentary retinopathy may theoretically occur but have not been reported with Dartal. Severe hypotension following recommended doses occurs more commonly in patients who are also afflicted by other medical disorders such as mitral insufficiency or pheochromocytoma, and particular attention should be paid to such a possibility although this has not been observed with Dartal.

Adult Dosage: One tablet three times a day.

Pro-Banthine® 15 mg.
(propantheline bromide)
with
Phenobarbital 15 mg.

Warning: May be habit-forming.

For *Indications, Contraindications, Precautions, Side Effects* and *Dosage* see Pro-Banthine. In addition, phenobarbital should be administered with caution to patients with liver disease, mental disturbances or a significant degree of hypoxia.

Pro-Banthine P.A.®
prolonged acting brand of propantheline bromide

For *Indications, Contraindications, Precautions* and *Side Effects* see Pro-Banthine.

Dosage Form: Capsule-shaped, compression-coated, peach tablets of 30 mg. for oral use.

Dosage: The recommended initial dosage is one tablet in the morning and one at night.

084

SEARLE

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Need for AMA Dues Increase Explained

The American Medical Association's House of Delegates in June approved a $40-a-year increase in AMA dues, raising them to a total of $110.00 a year.

In an effort to determine the need for the increase, the American Medical News has conducted a series of interviews with Max H. Parrott, M.D., chairman of the Board of Trustees, and Burt L. Davis, M.D., chairman of the Finance Committee of the Board.

Following is the first of a series of articles based on those interviews.

Q. Dr. Davis, what were the factors leading the Board to ask for a dues increase this year?

A. To oversimplify, it became apparent that we couldn't live within our income at its present level. In fact, we're operating at a deficit this year. Actually, it was a combination of things—inflation, fiscal uncertainties in the future, and the need for more and better AMA programs in the years ahead.

Q. Let's discuss inflation first. How has that affected AMA?

A. I don't think there are any doctors in private practice today who aren't aware of the increased costs of doing business. Our figures show that inflation is affecting AMA about 6% a year. Perhaps that doesn't sound like much, but when you start talking about dollars, you come up with some alarming figures.

For example, our operating expenses this year are estimated at $32,024,955; that's including about $25 million for programs, $1.5 million for costs of occupancy, including property taxes, and $6.7 million in administrative costs. In 1967—the last year dues were raised—operating expenses were $28,371,000, with $21,411,000 for programs, $1,285,000 for occupancy, and $5,675,000 for administration.

Now, if you figure the 1967 costs in 1970 dollars, the programs for that year would have cost $32,910,000—more than they're going to cost this year.

Q. Do things look any better in the future?

A. I wish they did, but if inflation keeps on at its present pace, it will add nearly $2 million to our costs in 1971, and another $2.25 million in 1972. I should mention that these figures don't include any provision for taxes on our "unrelated business income"—the status of which is still in doubt—nor do they include expansion of our programs and activities.

Q. What effect is this having on AMA activities?

A. We've had to do some curtailing, of course. As an example, in 1967, one of our important councils held eight meetings for a total cost of $30,000. This year, that same group will meet only seven times, and it'll still cost $38,000.

Q. Some control can be exerted over such items as meetings and travel. What about the non-controllable costs?

A. That's a tough problem. Such things as postage and taxes are controllable by the government—there's not much we can do about it. Just one more example—this year the AMA will pay $325,000 to the government as its contribution to Social Security for its employees. These taxes have gone up 19.05% since 1967. Postage is another big item for us, and the postal rate increases have had a definite effect.

These are the kinds of costs we can't do anything about—when they go up, we have to pay the increases.

Q. What about salaries—are they in the same category?

A. Salaries are a particular problem, because, as AMA programs expand, more people are required to staff them. And salaries have to keep going up or the high-caliber people we want won't be able to work for us. In 1967, we had 982 employees; today just over 1,000, but the number of professional people has increased about 13%. Three years ago, our total payroll was $8.4 million; this year it'll be just over $11 million. And we'll pay $1,081,000 in benefits—including Social Security—whereas the total was $905,000 in 1967.

We're doing everything we can to hold payroll costs down. But our increasing involvement in major programs makes it necessary that we hire more and better professional people for the staff.

I also want to mention that in figuring our future needs, we included an eight per cent inflation factor in all salary estimates. I'm sure you've noticed that a lot of unions have won contracts calling for much bigger increases. In fact, the Labor Dept. said major union settlements during the first half of the year included a median increase of 9.7% a year in wages and benefits.

For most of the other items in the AMA budget, we used an inflation factor of 5.8% a year. All these estimates, of course, are just educated guesses—if inflation accelerates, we'll need more; if the increase slows, we'll be ahead of the game.

Q. Dr. Davis, can you give us some thoughts about the Association's sources of income and how they look in the future.

A. To begin with, you should realize that for many years, our two main sources of income have been advertising and dues. There are some other sources—subscriptions, books, pamphlets, royalties, sale of exhibit space, and return from our investments—but advertising and dues are our main support.

Ten years ago, the AMA got 50% of its income from advertising; only 23% came from dues. This year, we'll get 39% of our income from dues; only 34% from advertising.

Q. What's the significance of the change?

A. We've felt for some time that dues are our most stable income source. And, the effect of the tax bill enacted by the last session of Congress is important. That bill contains a provision which levies a tax on profit from advertising in AMA publications. In essence, the government has said it intends to tax otherwise tax-exempt organizations for profit-making activities which aren't directly related to their tax-exempt purposes. While this is a disputable matter, the Internal Revenue Service has indicated that it considers drug advertising in scientific journals taxable income. We don't know for sure how much impact this will have on AMA, nor can we make precise estimates for future costs. But the government has made it obvious to us—and a lot of other tax-exempt organizations—that we'll have to rely upon dues income as the chief source of revenue in the future.

Another factor to consider is that both dues and advertising income are eroded by inflation, but each dollar of profit from advertising, when taxed, will actually be worth only 52 cents.

Q. In other words, overdependence on advertising revenue would put the AMA in a dangerous financial situation?

A. That's right—we've long felt that dues are the most stable source of income we can have. In fact, four years ago the Board and our accountants agreed that at some point, we'd reach an upper limit on our non-dues income. Based on the past few years' figures, that limit appears to be about $19.5 million, but it'll be less when taxes are levied on advertising.

Q. What would happen if there were no outside income at all?

A. To support the programs we now have in operation, dues would have to have been $188 for 1970—to put it another way, each of our members is receiving $188 worth of services for $70.

Q. Dr. Davis, what about the reserves requirement set by the House of Delegates?

A. At the beginning of this year, we had $15.2 million in liquid reserves, which isn't sufficient to meet the House's requirement of 90% of our operating costs. That would require about $28 million in reserves. Further, our reserves must contain money to cover the eventuality that we have a tax liability for advertising revenue for 1968-69-70. Of course, in future years, beginning with the fiscal year that starts Dec. 1, such taxes would come out of operating funds.

Q. I think everyone's aware of the decline in stock prices. Has this affected AMA reserves?

A. It certainly has. The decline hit us just like it did everyone else—at one point our portfolio declined in value about 15% in two months. In the last fiscal year, the value of our securities investments dropped by about $1.3 million, and this certainly complicates our financial planning.



ABSTRACTS, BOOK REVIEWS

DISABILITY IN ANTIQUITY

Haj, Fareed, New York, Philosophical Library, Inc., 1970.

This book provides a fascinating backdrop for the current study of rehabilitation. It focuses on the major medical and social causes of disability in the Near East during the Middle Ages. The author covers disabling results of communicable diseases, injuries from war and punishment, and disabilities appearing in old age. He also examines mental retardation and mental illness. The book should interest not only those serving handicapped persons, but students of ancient and medieval history, with particular respect, of course, to medicine.

W. D. SNIVELY, JR., M.D.
Evansville

WINE AND THE DIGESTIVE SYSTEM

Lucia, Salvatore Pablo, San Francisco, Fortune House, 1970.

Wine is probably our earliest alcoholic beverage. Indeed, the present gigantic problem of alcoholism might be of considerably less magnitude if wine had remained our sole alcoholic beverage. This book, a selected annotated bibliography, presents brief abstracts on the effects of wine and its constituents on various segments of the digestive tract, including the stomach, the large and small intestines, liver, gall bladder and the pancreas. Summarizing an enormous amount of literature as it does, it should prove of considerable value to those interested in further investigation in the field. Useful guides are given concerning the proper use of wine.

W. D. SNIVELY, JR., M.D.
Evansville

PHARMACOLOGY AND PATIENT CARE

Garb, Soloman; Crim, Betty Jean; and Garf, Thomas, New York, Springer Publishing Co., Inc., 1970.

PHARMACOLOGY AND PATIENT CARE (Third Edition) presents an authoritative and useful compendium on the application of modern knowledge of pharmacology to the clinical practice of medicine. The reputation of the senior author goes far in establishinng the authenticity of the book. After a preliminary section on general considerations, which covers such widely varied but important subjects as role and responsibility of the nurse, durgs and the unborn child, drugs in young infants and the currently crucial problem of drug addiction, the pharmacology of drug groups is well covered and, indeed, encompasses the major porion of the book. Finally, the use of drugs in the care of patients receives careful attention. Although written primarily for the nursing student, this book should be of considerable usefulness to the practicing physician, particularly the family physician.

W. D. SNIVELY, JR., M.D.
Evansville

FETAL AUTONOMY

Ciba Foundation Symposium, edited by G. E. W. Wolstenholme and Maeve O'Connor, J. & A. Churchill Ltd., London, England; 326 pages and 73 illustrations, 1969.

The chairman of this symposium, Prof. G. S. Dawes, in his very first sentence states that, "The mammalian embryo establishes contact with its mother while concealing its own immunological identity. . . ." Also, we all know that the conceptus gets its genes in equal parts from father and mother. Ergo, it must be an *allograft* in the much abused exact meaning of the word. I received the very definite impression that we were about to participate in an exploration of the precise mechanisms that enable the fetus to *conceal* its immunological identity while snugly ensconced inside its mother's womb. Certainly, some light would be shed (I thought) on the biochemistry of runt disease and host rejection of such things as heart transplants.

Well, three-hundred-odd pages later I was still awaiting the clarification. Not that there was a total hiatus. We did have a fairly interesting resume anent "fetal metabolism," "fetal circulation," "role of placental lactogen," etc.

However, my question remained unanswered; of course, that is still for the future.

Nevertheless this is an excellent volume for the obstetrician and the gynecologist; maybe, also, the physiologists and biochemists busy with embryology. As usual, the printing, binding and paper are impeccable; I spotted no typo errors.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

HOMEOSTATIC REGULATORS

Ciba Foundation Symposium—edited by G. E. W. Wolstenholme and Julie Knight—J. A. Churchill Ltd., London; 327 pages with 84 illustrations and numerous tables; 1969.

The tremendous continuing development of absolutely basic science is giving the practicing physician (no matter how much he reads) an increasing sense of frustration. It is truly refreshing to come across a symposium such as this one. A score plus of experts discuss "their things" in such a fashion that you and I can scan their discussions and make the effort to comprehend just what they think they really know and what their present hang-ups are.

In his introductory remarks, the chairman raises the issue of the *milieu interieur* first outlined by Claude Bernard; what are the regulators of the feedback mechanisms that distinguish normal growth from cancer (uninhibited growth; just what enzymes are the backbones of these CHALONES (the secretions produced by the tissues to inhibit the mitotic activities of themselves); where do the cell membranes actuate inter cellular coupling; just what does gene transcription really do and where does the immune mechanism and viral intrusion come in? Then the entire symposium is devoted to the facts that have been learned and the enigmas that remain (as yet) unresolved. This all is not easy reading; still I felt rewarded when I made the effort to comprehend just what was being said.

As usual, the binding, text and paper are of the highest quality. The illustrations are superb. This monograph certainly should grace the libraries of hospitals and medical schools. The adventurous M.D. may even want a copy for his own shelf. Congratulations to the Ciba people.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

MEMBRANES OF MITOCHONDRIA AND CHLOROPLASTS

ACS Monograph edited by Efraim Racker—Van Nostrand Reinhold—322 pages, profusely illustrated by figures and tables—1970—$20.00.

The advances in the comprehension of the structures and functioning of the intra-cellular organelles has been breath-taking. The electron microscope and gas spectroscopy have increased our analytic capacities by the order of several magnitudes. Today we are able to discuss soberly the *Danielli* and subunit models of the cell membranes and talk about the biochemical and stereo composition of the same! The oxidation chain of the inner chloroplast membrane and the resolution of the coupling device—the intra-mitochondrial distribution of enzymes—the precise activities of the metals and other cations as well as the transport of the anions; all these and many more are brought almost into focus to be understood by the attentive student (as well as the expert).

The printing, binding and format are truly superb. It is a mite too advanced for the average M.D. I would recommend a careful scanning of the well-thought-through summaries gracing the end of each chapter. Certainly, the hospital and medical school libraries should have this volume decorating their shelves.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

PLASMA TESTOSTERONE LEVELS IN MALES WITH THE 47,XYY KARYOTYPE

W. H. Price (Western General Hosp., Edinburgh) and J. Van Der Molen

J. Endocr. 47:117-122 (May) 1970.

No difference could be demonstrated between the plasma testosterone levels in 17 men with the 47,XYY karyotype and appropriately selected controls. Significantly higher levels of testosterone were recorded in both 47,XYY, and 46,XY, men at a maximum security hospital than in men with both karyotypes in other hospitals and in the general population.

SEX CHROMOSOMES, CRIME, AND PSYCHOSIS

G. R. Clark et. al. (Elwyn Institute, Elwyn, Pa.)

Amer. J. Psychiat. 126:1659-1662 (May) 1970.

Questioning the belief that XYY men are predisposed to violent behavior, the authors compared XYY men in penal institutions with men with the Klinefelter syndrome (XXY). They found little difference between their behavior and criminal records. The authors feel that XYY men have been stigmatized falsely and their involvement in crimes and antisocial behavior may not be significantly different from the normal individual's.

TEFLON EMBOLISM FROM STARR-EDWARDS VALVES

N. R. Niles (Univ. of Oregon Medical School, Portland)

J. Thorac. Cardiovasc. Surg. 59:794-799 (June) 1970.

Deterioration and fragmentation of Teflon of the prosthesis have been found in 12 patients with Starr-Edwards valves. The time interval following operation was as brief as 36 days. In four patients similar material was found in peripheral organs. The shortest interval from operation to death was one year. Some of the cardiac, cerebral, and other infarcts from which these patients commonly suffer may be the result of Teflon embolism.

SILVER ALLANTOINATE AS INHIBITOR OF CUTANEOUS BACTERIA UPON HANDS OF OPERATING ROOM PERSONNEL

W. F. Ballinger II, et al. (Washington Univ. School of Medicine, St. Louis)

Ann. Surg. 171:836-842 (June) 1970.

The addition of 2% silver allantoinate to biosorb powder is an effective way to reduce the number of bacteria recoverable from the hands of operating room personnel. The number of bacteria at the end of operations exceeded the number after scrubbing in 35% of the control hands but in only 8% of those treated with silver allantoinate powder. Significantly fewer bacteria were grown from the hands of scrub nurses and senior staff when silver allantoinate power was used than when it was not. Personnel who consistently had bacteria cultured from their finger tips at the end of operations despite the use of the silver powder had, with one exception, fewer bacteria at the end of operation than after scrubbing. Although one person had more bacteria cultured from his fingers at the end of operations than immediately after scrubbing and applying silver powder, the mean increase in numbers was approximately 50% of the increase observed when no silver powder was used. Silver allantoinate inhibits in part the rising bacterial count which occurs when gloves are punctured and fingers become bloody.

MANAGEMENT OF BLEEDING STRESS ULCERS

J. Kunzman (Kaiser Foundation Hosp., Walnut Creek, Calif.)

Amer. J. Surg. 119:637-639 (June) 1970.

Bleeding stress ulcers developed in 74 young men without previous ulcer disease and with major injuries received in the Vietnam war. Of four forms of management for this complication the best results were obtained by nonoperative treatment. Surgery was used only in the event of rapid blood loss. Vagotomy and pyloroplasty with oversewing of ulcers and ligation of bleeding points appeared to be the most effective of the three types of surgical procedure used. The aspect of management having the greatest therapeutic potential for this complication is rapid aggressive treatment for the underlying illness.

GYNECOLOGICAL COMPLICATIONS OF WATER SKIING

D.C. Morton (District Hosp., Gosford, NSW, Australia)

Med. J. Aust. 1:1256-1257 (June 20) 1970.

Illustrations are presented of three types of gynecological complications occurring as a result of water skiing, and attention is drawn to the necessity for the use of adequate protective garments for all female water skiers. Lacerated vaginal vault occurred in one case due to forcible impact of the perineum against the water surface. Incomplete abortion was caused in another, and injury in a third case caused salpingitis. In all three cases only standard swim-suits were worn.

FIBROCYSTIC DISEASE IN WOMEN RECEIVING ORAL CONTRACEPTIVE HORMONES

R. E. Fechner (Methodist Hosp., Houston)

Cancer 25:1332-1339 (June) 1970.

Breast tissue with the diagnosis of fibrocystic disease was examined from 25 women taking oral contraceptives. Slides from these cases were coded and mixed with slides from patients of the same ages having fibrocystic diseases who denied hormone usage. Various epithelial alterations were tabulated without knowl-

edge of hormone therapy. The paients receiving oral contraceptive hormones presented a spectrum of epithelial alterations qualitatively and quantitatively similar to their controls. Neither specific nor bizzare epithelial alterations were recognized.

UNILATERAL PULMONARY EDEMA AFTER PLEURAL ASPIRATION

D. H. Trapnell and J. G. B. Thurston (Westminster Hosp., London)

Lancet 1:1367-1370 (June 27) 1970.

In four patients unilateral pulmonary edema developed when a large collection of either air or fluid was removed from the leural cavity. One patient died as a result. In each patient pulmonary edema developed in the lung that had been compressed by the pleural air or fluid. The volume of any pleural aspiration should be kept to less than one liter if the underlying lung has been compressed for more than a week and below 1,500 ml in any circumstances.

ADVANTAGES OF BYPASS OPERATIONS OVER RADICAL PANCREATODUODENECTOMY IN TREATMENT OF PANCREATIC CARCINOMA

G. Crile, Jr. (Cleveland Clinic Foundation, Cleveland)

Surg. Gynec. Obstet. 130:1049-1053 (June) 1970.

In a series of 28 patients treated by radical pancreatoduodenectomy for adenocarcinoma of the head of the pancreas, the longest period of survival was 22 months. In other series of 28 patients with similar carcinomas treated by bypass procedures, the average survival was six months longer than in those treated by radical operations. Four patients lived from 24 to 42 months. The average patient with an adenocarcinoma of the head of the pancreas that is big enough to be palpated with live longer and more comfortably if no attempt is made to take a biopsy specimen or to remove it.

POSTOPERATIVE HEMORRHAGE FROM STRESS ULCERATION OF STOMACH AND DUODENUM

R. S. Flowers (Straub Clinic, Honolulu), K. Kyle, and S. O. Hoerr.

Amer. J. Surg. 119:632-636 (June) 1970.

Nineteen patients had serious upper gastrointestinal hemorrhage within 14 days after undergoing an operation not on the uper gastrointestinal tract and not for trauma. The source of the bleeding was identified at emergency operation in 17 patients and at autopsy in 2. There were two distinct types of lesions—chronic peptic ulcer of the stomach or duodenum (four cases) and acute superficial ulcers (15 cases); a few were single and discrete, but most were multiple and sometimes confluent. Bleeding was arrested in all 17 operative cases by a variety of surgical procedures. Emergency operation might have been beneficial in the two patients who died without it. For bleeding from chronic peptic ulcer, management may follow conventional lines; gastrectomy with or without vagotomy or, alternatively, vagotomy, over-sewing of the ulcer base, and pyloroplasty. For acute single superficial ulcerations, oversewing of the ulcer base in the stomach or duodenum accompanied by vagotomy and pyloroplasty appears to be satisfactory.

AGE DISTRIBUTION OF CANCERS CAUSED BY OBSTETRIC X-RAYS AND THEIR RELEVANCE TO CANCER LATENT PERIODS

A. M. Stewart (8 Keble Rd., Oxford, England) and G. W. Kneale.

Lancet 2:4-9 (July 4) 1970.

A comparison of the age distrubutions of 5,802 children with spontaneous or idiopathic cancers and 1,045 children who were x-rayed in utero before cancer developed revealed 423 extra x-rayed cases, 20 of which were ascribed to cerebral tumors diagnosed within a few weeks of birth after threatening to obstruct labor. The remaining 403 cases were probably caused by the radiations, and thus had latent periods which corresponded to the age when symptoms developed. These radiogenic cases were evenly distributed between ten diagnostic groups and had latent periods which not only varied with the type of cancer but also implied continuous growth of the tumors from the dates when the x-rays were first taken. The relevance of these findings to adult cancers is discussed in terms of the gene-selection theory and in relation to the observation that latent periods for childhood and adult leukemias are not significantly different.

CHROMOSOMAL ANOMALIES IN SPONTANEOUSLY ABORTED HUMAN FETUSES

R. K. Dhadial, A. M. Machin, and S. M. Tait (Guy's Hosp. Medical School, London)

Lancet 2:20-21 (July 4) 1970.

Chromosome studies of 423 spontaneous abortions (410 singleton and 13 pairs of twins), showed 101 abortuses with chromosomal anomalies. Of 39 in which the spontaneous nature was in doubt, only one had an abnormal karyotype and 25 therapeutic terminations were chromosomally normal. Of the chromosomally abnormal abortuses, 46.6% were autosomal trisomics, 30.6% were interpreted as sex chromosome monosomics (45,X) 12.8% were triploids, and among the remainder there were chromosomal mossaic, double trisomic, and tetraploid abortuses, and there were three with translocations.

TWO CASES OF TRANSFUSION MALARIA

A. E. Dike (Stoke Mandeville Hosp., Aylesbury, England)

Lancet 2:72-73 (July 11) 1970.

Only five cases of malaria caused by blood transfusion have been reported in England since 1936, though there may have been others not reported. With increasing intercontinental travel, the risk of blood donors being malaria carriers is a very real one. The author reports two cases of transfusion malaria seen since 1967.

SKIN CANCER DUE TO FLUORESCENT LIGHTING?

R. Diethelm (Spezialarzt FMH fur Chirurgie, Altdorf, Switzerland)

Schweiz Med. Wschr. 100:1159-1160 (July 4) 1970.

Cancer of the skin in five patients with a history of many years' exposure of fluorescent lighting at work raises the question of whether the ultraviolet rays emitted by standard fluorescent tubes may give rise to this disease.

CLINICAL EXPERIENCE WITH THE G-SUIT

M. H. Espinosa and J. H. Updegrove (Easton Hosp., Easton, Pa.)

Arch. Surg. 101:36-39 (July) 1970.

Use of the G-suit in more than 20 cases demonstrated its effec-

tiveness in the control of intra-abdominal bleeding and restoration of effective blood pressure. When inflated, the suit surrounds the body from the xiphoid process to the ankles. Necessary examinations, insertion of catheters, etc, should be accomplished before the application of the G-suit. The immediate pressor response must be attributed to reduction of the volume of the vascular bed. Control of bleeding may result from circumferential compression of the wall of the bleeding vessel. An abrupt fall in blood pressure can be anticipated upon the release of the pressure from the G-suit, and adequate volume replacement must precede or accompany deflation of the suit.

ALIMENTARY (POSTGASTRECTOMY) HYPOGLYCEMIA

R. A. Burton and N. H. Raskin (Univ. of Calif. Medical Center, San Francisco)

Arch. Neurol. 23:14-17 (July) 1970.

Alimentary hypoglycemia generally denotes the occurence of low blood glucose 1½ to 3 hours postoperatively in a patient who has undergone gastrectomy. While seizures are a well-known manifestation of hypoglycemia due to pancreatic adenoma, it has remained unclear whether postprandial hypoglycemias are ever sufficiently profound or rapid in evolution to compromise cerebral function. Two patients with documented alimentary hypoglycemia who presented with major motor as well as psychomotor seizures as manifestations of hypoglycemia are discussed. Seizures ceased upon institution of high-protein, low-carbohydrate diet. Alimentary hypoglycemia ranks only second to reactive (functional) hypoglycemia as a cause of spontaneous hypoglycemia. A patient who has undergone partial gastrectomy and subsequently develops postprandial episodic cerebral dysfunction should be evaluated for alimentary hypoglycemia. Nausea, vomiting, headache, diarrhea, diaphoresis, and hunger need not accompany neurologic symptoms. Diagnosis can be established by an oral glucose tolerance test, with quarter-hourly glucose measurements. Dietary treatment is generally effective.

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OUTBREAK OF RUBELLA IN VACCINATED POPULATION

T. W. Chang, S. DesRosiers, and L. Weinstein (171 Harrison Ave., Boston)

New Eng. J. Med. 283:246 (July 30) 1970.

An epidemic of rubella involving a child care center six months after a group of susceptible members of the population had been immunized with Cendehill vaccine is described. All those not vaccinated, who served as controls, were invaded by the virus. Only 50% of the children developed clinically evident disease; the diagnosis in the others was made because of the appearance of substantial levels of hemagglutinin-inhibiting (HI) antibody. Forty-five percent of the youngsters who had been given vaccine developed complement-fixing antibody and significant elevation of HI antibody after the epidemic, while none exhibited clinical manifestations of rubella. Two questions are raised by these observations: Will "booster" doses of vaccine prevent the syndrome of infection without disease? Does "rubella without a rash" occurring early in pregnancy in women immunized prior to conception increase the risk of fetal difficulty as it is known to do in immunized pregnant patients?

ACUTE DILATATION OF COLON IN CROHN'S DISEASE

S. L. Javett and B. N. Brooke (St. George's Hosp., London)

Lancet 2:126-127 (July 18) 1970.

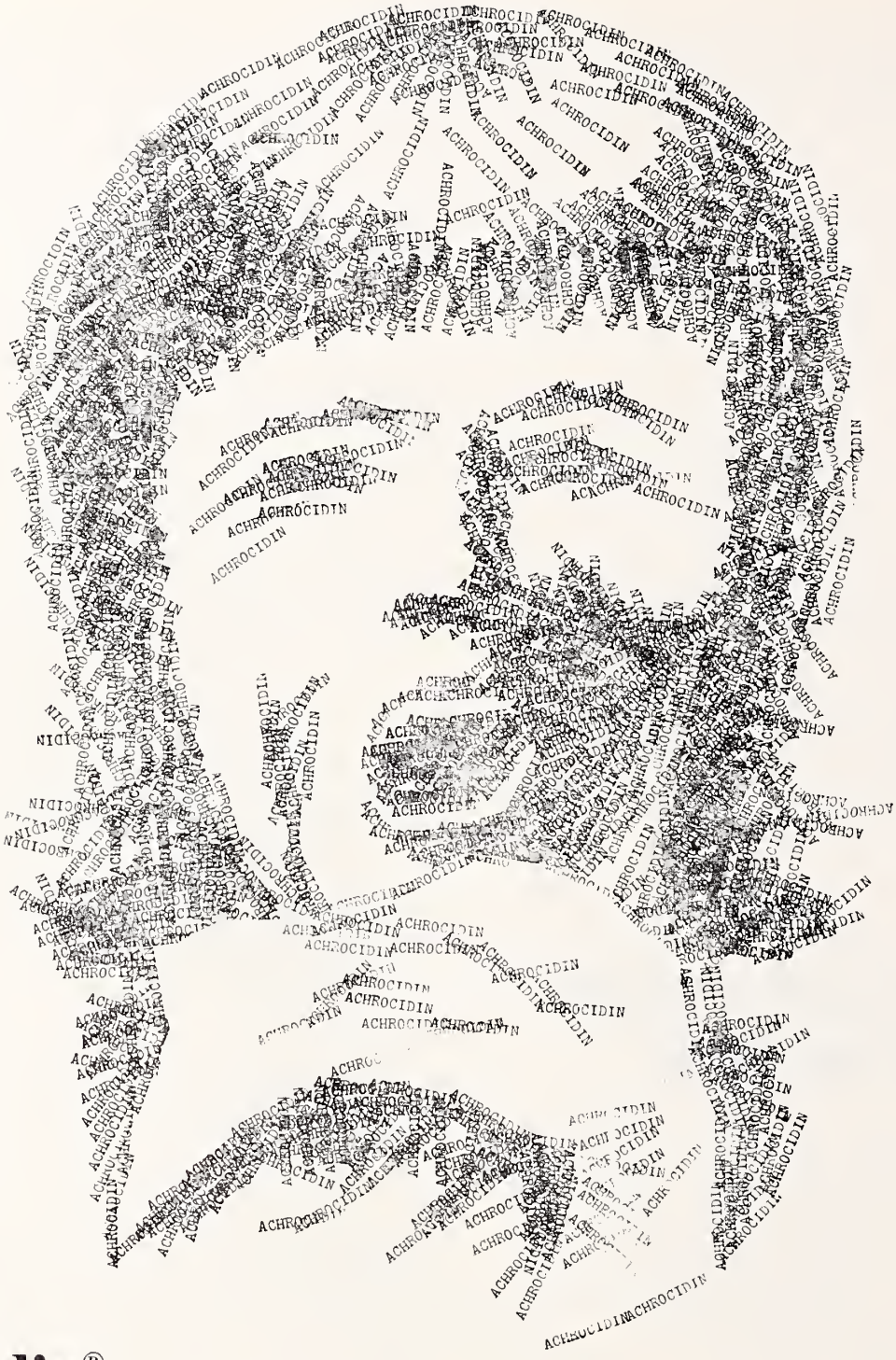
Acute toxic dilatation of the colon is a complication well recognized in ulcerative colitis, but not in Crohn's disease. Five cases of acute dilatation are presented with evidence of Crohn's disease either at the time of operation or subsequently. One case showed two free perforations of the dilated colon associated with subphrenic abscess, another full penetration of the bowel wall was sealed off.

SURGICAL MANAGEMENT OF GASTRODUODENAL BLEEDING STRESS ULCER

H. Roth (Kantonsspital, Munsterlingen, Switzerland)

Schweiz Med. Wsch. 100:1278-1280 (July 18) 1970.

Experience in 29 cases of post-operative gastroduodenal bleeding stress ulcer is briefly reported. Nine of 15 conservatively treated patients recovered, while six died. Ten of 14 surgically treated patients survived. In five of these successfully operated ulcers follow-up studies after two to eight years showed no ulcer symptoms. Bleeding ulcers should usually be treated by minimal surgical intervention, generally limited to simple gastrotomy or duodenotomy and suture of the bleeding ulcer. Gastric resection or vagotomy should be performed only in the presence of special indications. ◄



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Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

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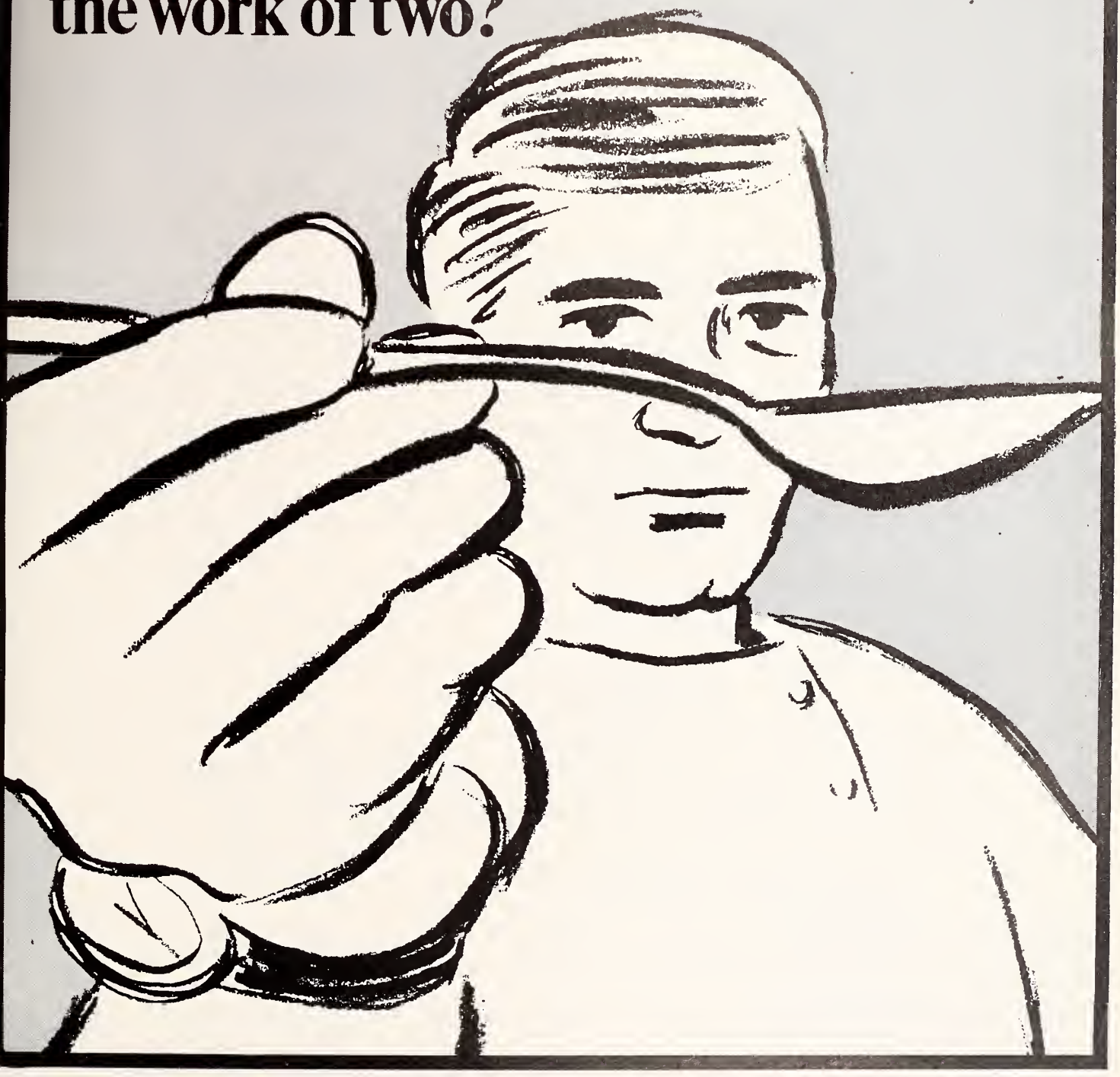
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Blue Cross and Blue Shield Again Return Most in Benefits

(One of a series)

Indiana Blue Cross and Blue Shield returned more of its membership fee income to pay medical bills than any of the other leading health insurers in the country last year, according to the 1970 *Argus Chart of Health Insurance,* a standard reference publication for the insurance industry.

During the year Indiana Blue Cross and Blue Shield returned 96% of its earned income to pay its members' bills for care by hospitals, physicians and other health care providers.

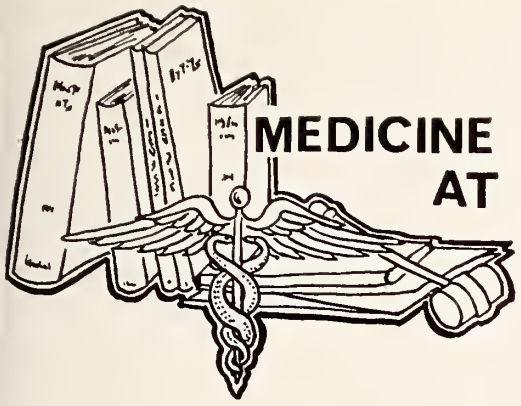
A list of health insurers earning more than $100,000,000 during the year, throughout the country for all but Indiana Blue Cross and Blue Shield, ranged downward to a 57% payout for all kinds of policies. For individual policies only, Indiana Blue Cross and Blue Shield again were first with 91% in a list that ranged to a low return of 20%.

The percentage of income returned in benefits is widely accepted as the index which best reflects to what extent the customer is getting his money's worth.

The *Argus Chart* results:

Company*	Individual Only Per Cent Returned	Group and Individual Per Cent Returned	Premiums Earned (Millions of Dollars)	Combined Claims Incurred (Millions of Dollars)
Indiana Blue Cross and Blue Shield	91	96	163	156
Mutual of Omaha	63	74	428	318
Equitable Life	61	92	474	435
Lincoln National Life	60	88	122	108
New York Life	58	77	156	120
Metropolitan Life	57	87	757	661
Continental Assurance	54	89	108	96
Travelers	53	91	821	747
Washington National	51	73	116	85
Prudential	50	83	669	557
Aetna Life	49	92	939	867
Occidental Life of California	49	88	164	145
John Hancock	49	86	288	249
Provident L & A	48	86	205	176
Bankers Life & Casualty	46	57	180	103
Continental Casualty	41	72	369	267
Connecticut General	20	91	413	375

* All companies listed in 1970 Argus Chart earning $100,000,000 or more arranged in order of per cent returned on individual (direct pay) basis. Income is nationwide in each case except Indiana Blue Cross and Blue Shield, which is Indiana only.



MEDICINE AT LAW

Patient Recovers Damages for Infection After Caudal Anesthesia—An obstetrician, an orthopedist, and a physician who administered a caudal anesthetic to a woman during delivery were held liable for disabilities resulting from an infection at the site where the anesthetic was injected.

In her suit against the physicians and the hospital, the patient alleged that the first attempt to induce caudal anesthesia was ineffective and a second injection was required. Following delivery, she had severe pain in her low back and her temperature elevated. The obstetrician consulted an orthopedist, who treated the patient for low back strain and discharged her from the hospital. She claimed that a week later she was re-admitted to the hospital with a large abscess at the site of the injection and that further treatment was required.

The patient claimed in her suit that at the site of the caudal block an abscess formed which was infected with strep fecalis and E. coli bacteria. The patient alleged that the bacteria could have occupied the area only through the negligence of the physicians.

The patient further claimed that the hospital anesthesiologist who was in charge of administering the anesthetic broke sterile technique, and that he may have been responsible for the infection by having punctured the rectum in the first attempt at inducing anesthesia. She further alleged that the obstetrician and the orthopedist were negligent in failing to diagnose the abscess.

The woman claimed that she had a lumbosacral abscess approximately ten inches in diameter which required two surgical procedures to correct. The orthopedist who testified as a witness for the physicians and the hospital admitted that the patient had permanent residuals, consisting chiefly of limitation of motion and susceptibility to strain. The patient claimed medical expenses in the amount of $4,626 and other expenditures in the amount of $1,400.

The physicians and the hospital contended that sterile techniques were followed and that infection is a risk in giving a caudal anesthetic because the patient cannot be sterilized beneath the skin. They stated that the infection did not manifest itself until four days after the patient's discharge, at which time she developed swelling, heat and local tenderness. They further urged that the patient had no signs of infection before this time and that, therefore, it could not have been diagnosed.

The physicians and hospital contended that the patient complained of generalized low back pain after delivery and that the most common cause of back pain after delivery is a mechanical low back strain and not an infection. They argued further that the proper standard of practice was followed and that the delayed diagnosis was not a proximate cause of the injury.

The jury returned a verdict for the patient in the amount of $65,000, holding against the three physicians but absolving the hospital. The physicians filed a motion for a new trial. —*Campbell v. Children's Hospital* (Cal. Super. Ct., San Francisco Co., Docket No. 556615, 1970).

Recovery Denied for Blindness of Premature Infant—A 19-year-old college student was denied recovery from a hospital and a physician for total and permanent blindness which she alleged was caused by improper treatment at the time of birth.

It was contended that the birth was three months premature and that the child was placed in an incubator and oxygen was administered for cyanotic spells. The girl further charged that the oxygen caused retrolental fibroplasia and that, as a result, she became blind. The student claimed that the hospital was negligent in failing to keep adequate records. She said that the cause of the disorder was not discovered until five years after birth.

The hospital records were taken to the jury room. The hospital and the physician claimed that placing an infant in an incubator and administering oxygen was standard pediatric procedure in 1950, the year of the girl's birth.

The case against the physician was dismissed by the court and the jury found in favor of the hospital. A special interrogatory was submitted to the jury which asked, "Did hospital fail to follow standard at time, causing plaintiff's blindness?" The jury answered the interrogatory in the negative.—*Araman v. Chicago Wesley Memorial Hospital* (Ill. Cir. Ct., Cook Co., Docket No. 68L-3451, June 22, 1970).

Hospital Records Admissible in Narcotics Prosecution—Hospital records showing treatment given a drug addict shortly after his arrest on drug charges are admissible as

evidence tending to show that the addict possessed drugs for the purpose of unlawfully using them as an addict, the highest court of Louisiana held.

After surveillance, a suspected drug addict was arrested on a charge of unlawful possession of narcotics. On the day after the arrest, the accused was taken to a hospital where he was treated for withdrawal symptoms.

At the trial, the court admitted in evidence hospital records showing a diagnosis of withdrawal symptoms and classifying the accused as a dilaudid addict. The accused was found guilty on the narcotics charge, and he appealed.

On appeal the accused contended that his constitutional rights were violated by admitting the hospital records in evidence. He claimed that since he was in a sick and helpless state at the time of his hospitalization he should have been provided with an attorney at the hospital to advise and assist him in protecting his rights.

He further argued that the hospital records were hearsay, and their admission in evidence violated the constitutional right of an accused to confront the witnesses against him. Violation of the physician-patient privilege was also claimed.

The Louisiana Supreme Court upheld the conviction. The court noted that the man was taken to the hospital at his own request and that after his admission, he was treated for withdrawal symptoms.

The court held that a state statute provided that hospital charts and records could be received in evidence as proof of the matters contained therein, provided that the person against whom the records were sought to be used was permitted to call as witnesses the persons who prepared the records.

The statute supplied a complete answer to the physician-patient privilege and provided for an exception to the rule prohibiting admission of hearsay evidence, the court ruled. Likewise, since the statute provided that the accused could call as witnesses the individuals who prepared the records, he was not deprived of his right to confront the witnesses against him.

The court concluded that the hospital records were properly admitted in evidence and affirmed the conviction.—*State of Louisiana v. O'Brien*, 232 So. 2d 484 (La. Sup. Ct., Feb. 23, 1970; rehearing denied, March 30, 1970).

Pharmacist Found Guilty in Medicaid Scandal—A pharmacist who allegedly collected $68,063 in unwarranted Medicaid payments was found guilty of fraud and conspiracy by a Maryland criminal court. He was fined $10,000 and may lose his license to practice.

The court felt that the druggist had master-minded a plan, which involved ten physicians, another pharmacist, and an accountant, to bilk the state of funds.

In another proceeding, the physicians were fined $1,000 each, and eight of them entered pleas of "no contest," which the court accepted. This plea allows the court to punish a wrongdoer without entering a verdict of guilty in the record.

If the physicians had been adjudged guilty, their licenses could have been revoked, and the Negro community in which they work would be deprived of their services, the court commented.—Washington, D. C., *Evening Star*, May 7, 1970.

Rented Second Car Not Covered by Physician's Auto Liability Policy—A rented second car which was available for frequent or regular use by a policyholder was not covered by the "non-owned automobile" clause of an automobile liability policy, an Illinois appellate court held.

An insurance company issued an automobile liability policy to a physician with the physician's wife as an additional insured. The coverage was extended to the use of a non-owned automobile by the policyholder, his spouse or relatives if they lived in the same household. A non-owned automobile was defined in the policy as an automobile or trailer which was not owned by or registered in the name of the policyholder and not furnished or available for the frequent or regular use of the named policyholder, his spouse, or any relative of either residing in the same household, other than a temporary substitute automobile.

The policy covered the physician's 1964 Pontiac. He needed a second car for use in his profession. He signed a rental agreement for an Oldsmobile. The monthly rate for the rental included the premium for liability insurance. While driving the rented car, the physician's wife struck a pedestrian and a motorcyclist, seriously injuring both. In the rental agreement there were no restrictions on the use of the car.

In the litigation that followed the accident, it developed that the Oldsmobile was not covered by the policy carried by the leasing company.

The insurance company that insured the physician brought suit seeking a determination of its obligations under the policy. Testimony indicated that the physician conducted his practice from his home and that no restrictions were placed on the use of the rented car by his wife. There was evidence that the wife had driven the car, but there was some conflict as to the number of times she had done so. In construing the clause of the policy which provided that the non-owned car coverage would not apply to an automobile which was furnished or available for the frequent or regular use of the policyholder or his spouse, the court noted that the evidence showed that the car was available for the frequent and regular use of the

physician's wife. Therefore, the car was not a non-owned car, and the insurance company was not liable under the policy.

The court ordered that the leasing company to whom the physician had been paying premiums on a liability policy covering the rented automobile must hold the physician and his wife harmless against all claims brought against them as a result of the accident.—*State Farm Mutual Automobile Insurance Company v. Berke,* 258 N.E. 2d 838 (Ill. App. Ct., May 21, 1970).

Physician Not Liable for Patient's Fall—A physician was not liable to a 12-year-old boy who allegedly tripped on a torn rug in the office and fell into a glass door, cutting his right hand and knee, an Illinois trial court held.

The wounds required 12 sutures. The youngster claimed that he was a business invitee and, therefore, the physician, as occupier of the premises, had a duty to warn him of dangers which the physician could discover by the use of reasonable care. The physician, however, denied that the rug was close to the exit and claimed that the child was playing near the door.—*Gonzalez v. Klovens* (Cir. Ct., Cook Co., Docket No. 65L-2786, April 9, 1970).

Insurance Company Joined with Physician as Party to Suit—A company insuring a physician on a malpractice policy may be joined with the physician in a malpractice action, a Florida appellate court held.

A former patient sued a physician, alleging negligent postoperative care. The company insuring the physician on a professional liability policy was made a party to the action. The insurance company sought to be dismissed from the action, urging that under the terms of the policy the patient did not have a claim against the insurance company. The company further claimed that an insurance company should not be joined in a suit against a policyholder.

The trial court held against the contentions of the insurance company and ordered that the policy be produced.

In affirming the ruling of the trial court, the appellate court held that a liability insurance carrier may be joined as a party with the policyholder if the insurance company has complete control over the litigation and responsibility for payment of the judgment and costs.—*Shipman v. Kinderman* 232 So. 2d 21 (Fla. Dist. Ct. of App., Feb. 24, 1970)

$400,000 Verdict Returned for Failure to Diagnose Cancer—A $400,000 jury verdict was returned against one of two California physicians charged with negligence in failing to diagnose a malignant breast lesion when the condition was alleged to be localized and capable of effective treatment.

The physicians' negligence, the patient contended, was the proximate cause of the extensive advancement of the disease prior to the time treatment was finally undertaken and was directly responsible for her unfavorable prognosis, both in terms of life span and terminal pain and suffering.

The patient, a 44-year-old housewife, had consulted the physician in 1966 concerning the presence of a small lump in her left breast. The physician, who was a general practitioner but specialized in obstetrics and gynecology, reportedly located the lump but advised the patient that it was no cause for concern and required no further examination until the following year.

At that time the patient returned, this time reporting an enlargement of the lump and a retraction of the nipple. A mammogram was thereupon ordered and interpreted by a radiologist, who reported the existence of a mass but characterized it as sclerotic tissue, exhibiting none of the classic signs of malignancy. Approximately one year later, in September, 1968, an internist diagnosed a malignant tumor with extensive metastasis. Both the original physician and the radiologist were charged with malpractice.

Medical witnesses for the patient asserted that the community standard of care required a biopsy after the lump was detected and that a diagnosis based primarily on the mammogram was insufficient.

Witnesses for the attending physician stated that the standard of care had been met and that it had not been proved that the physician's conduct caused the patient's injury. On the part of the radiologist, it was contended that his findings based on the mammogram had not misled the physician and were, in fact, supported by a later, independent interpretation.

A verdict awarding $400,000 was returned against the attending physician after two hours of jury deliberation, following a six-day trial. A judgment of nonsuit was entered as to the radiologist.—*Dichner v. Ross (Cal. Super. Ct., Fresno Co,* Docket No. 141047, 1970).

Physician's Failure to Notify Patient of Result of Pap Test—After a physician had ordered a Pap test made, his failure to notify the patient promptly of the finding that there was a possibility of carcinoma of the cervix was a proper question for the jury. Also a jury issue was the question of whether or not the patient was at fault in giving inaccurate information as to her address. The Minnesota Supreme Court refused to disturb the jury's verdict for the physician.

The patient consulted the physician for the purpose of obtaining a contraceptive device. As a routine matter, he procured a "Pap smear," which was returned in about two

weeks with a report that it was "suspicious for malignancy." He tried to reach the patient several times but was unsuccessful until five months later, when she came to pay her bill. She was then given another Pap smear test, with the same result.

A biopsy revealed an in situ carcinoma of the cervix about one millimeter in size. It was diagnosed as "early invasive." As a result, the patient said, she "underwent a series of treatments with cobalt and radium therapy which destroyed her ovaries, rendered her sterile, and precipitated symptoms of menopause."

The evidence showed that the patient had moved twice and had no telephone. She had told the physician that both she and her husband worked at the University of Minnesota, she as a secretary and her husband as an accountant. The information was inaccurate, and the physician was unable to identify and reach them through the University. He finally spoke to her mother and asked that the patient call his office. She claimed that she had given the physician's office her changed address and that he could have reached her at any time by mail.

The court ruled that the physician was under a duty to take "whatever steps were reasonable" to notify the patient of the result of the test and that it was proper to submit the question of the patient's contributory negligence to the jury. While the jury might well have come to a different conclusion, the court said, it had the right to render a verdict for the physician. The court refused to hold, as a matter of law, that the evidence did not support the jury finding. The judgment was affirmed.—*Ray v. Wagner*, 176 N.W.2d 101 (Minn-Sup. Ct., March 20, 1970).

Physician not Liable for Child's Death Where Symptoms Were Not Alarming—The symptoms of a child who later died were not considered alarming by either the examining intern, the physician consulted, or the parents and, therefore, the evidence supported a verdict finding the consulting physician not guilty of negligent homicide, a Georgia appellate court ruled.

The child, a small boy, became ill and was brought to the emergency room of the hospital at 11 p.m. It was believed that he had been bitten by an insect earlier in the day. The examining intern found him suffering from an elevated temperature of 102 degrees, a small red or bluish area on his chest where it was believed he had been bitten, and infected ear drums.

During the course of the examination, the intern learned that the child had been attended by a certain physician earlier. With the family's permission, the intern consulted the physician by phone, relating the symptoms he had found.

Then the intern gave the child a shot of phenobarbital to quiet him, a shot of penicillin, and two prescriptions to reduce the fever and to fight the infection in the ears. The parents took the child home but did not fill the prescriptions because of the late hour.

The child became seriously ill in the early morning and was dead on arrival at the hospital. The death certificate showed that death was caused by cerebral edema, acute hemorrhagic glomerulonephritis, and anaphylactic reaction to an insect bite.

The mother brought a suit against the physician who had been consulted by phone and the jury acquitted him of negligent homicide.

On appeal, the mother contended that a mistrial should have been declared because the physician's attorney, in closing argument, told the jury that the mother was asking them to convict the physician because he negligently killed the child. The appellate court agreed that "killed" was strong language, but, in light of the charge of negligent homicide, the court said that the language was accurate.

The appellate court also rejected the mother's argument that a requested jury instruction should have been given. The requested jury instruction was to the effect that if the jury found, from the evidence, that the child's symptoms were such as to require a prudent physician to conduct further tests before making a diagnosis, the jury should find the physician guilty. The court noted that this instruction was unfairly weighted in favor of the mother's position. Furthermore, since the evidence showed that none of the parties involved, including the parents, thought the child's symptoms were alarming, the evidence supported the jury's verdict that the physician was not guilty of malpractice.—*Rogers v. Black*, 173 S.E. 2d 431 (Ga. Ct. App., Feb. 12, 1970; rehearing denied March 3, 1970).

Insurance Denied for Death Due to Barbiturate Overdose—Recovery under the accidental death clause of an insurance policy was denied by a California trial court jury in a suit to recover for the death of a youth who took an overdose of barbiturates.

The youth resided with his mother and father. The mother was a registered nurse and the father a pharmacist. The parents alleged that their son inadvertently took an overdose of sleeping pills during a severe thunderstorm. It was claimed that barbiturate automation took over and that the youth took an overdose without realizing what he was doing.

The insurance companies contended that the death was suicide and that there should be no recovery under the accidental death provisions of the policy.

A physician testified that death was due to barbiturate poisoning. He stated that the Tuinal blood level was

"2.0 milligram per cent, 5-6 #200 milligram capsules."

A psychiatrist testified, in response to a hypothetical question, that there were no indications of suicide and that he was of the opinion that the youth did not commit suicide. A toxicologist testifying for the parents said that the young man must have taken ten 200 milligram capsules. After deliberating one day, the jury returned a verdict denying recovery. The policyholder made a motion for a new trial.—*Yanell v. Insurance Co. of North America and California State Automobile Association,* (Cal. Super. Ct., Alameda County, Docket No. H 11842, 1970).

Woman's Capacity to Bear Children Before Injury Presumed—A woman is presumed to have the capacity to bear children unless there is evidence to the contrary, an Illinois appellate court held. In a claim for loss of fertility and ability to bear children due to injuries allegedly suffered in an automobile accident, the injured woman is not required to show that she was fertile and able to bear children before the accident, the court ruled.

A 17-year-old guest passenger was injured when the driver drove the car off the highway and it traveled 144 feet after leaving the highway.

The injured girl claimed that, as a result of the accident, she would be unable to bear children. The driver argued that since there was no medical evidence that the girl was fertile and able to bear children before the accident, it was improper for medical experts to testify on the question of her ability to conceive and bear children after the accident.

The appellate court, in affirming a verdict awarding damages, stated that, in the absence of evidence to the contrary, she was presumed to have had the capacity to bear children.—*Enloe v. Kirkwood,* 256 N.E.2d 459 (Ill. App. Ct., Feb. 18, 1970).

Uncooperative Patient Denied Claim Under Hospitalization Plan—A patient who claimed that she was prematurely discharged from a hospital which participated in an insurance plan could not recover from the insurer the costs of surgery performed at another hospital, a California trial court jury held. The participating hospital said that she refused to keep an appointment with a staff physician who intended to have her readmitted for further examinations. The hospital also alleged that she failed to follow prescriptions and did not obey orders to diet.

The 51-year-old woman patient claimed that she had abdominal pain and bleeding. She was hospitalized for a week and was discharged after the physicians found no problem which related to her intestinal tract.

On the day of her discharge, the woman entered another hospital. At the time of admission she allegedly was suffering extreme pain. The physicians performed a total hysterectomy and found a benign cyst of the right ovary. There were no residual ailments or complaints.

The woman brought suit, alleging breach of contract under a health plan to which she had subscribed. She claimed that she had wanted to remain at the first hospital until the physicians found the cause of the abdominal pain and bleeding.

In defense, it was claimed that the patient had prevented further treatment. It was alleged that after her discharge from the hospital, she had refused prescriptions, had failed to diet, and had not kept an appointment for further examinations under anesthesia.

The woman claimed that she was given treatment which was below the proper standard of care and that, as a result, she suffered pain and mental anguish.

A physician testified as a witness for the health plan and stated that further examinations and surgical procedures were planned within a week after the woman's discharge from the hospital. He further testified that she did not suffer any acute distress at the time of her discharge. The physician reviewed the medical records at the hospital and found that the procedures followed were within the proper standard of care.

The jury, after deliberating for seven hours, returned a verdict in favor of the health plan.—*Fassiotto v. Kaiser Health Plan, Inc. and Permanent Medical Group,* (Cal. Super. Ct., San Francisco Co., Docket No. 603640, 1970). ◄

Continuing Education For Physicians

With this issue, *The Journal* inaugurates an expanded section on Continuing Education for Physicians, a section combining the features "Annual Meeting Dates of Professional Medical and Allied Organizations" and "Future Meetings, Seminars, Courses."

Continuing medical education is very much in vogue now. And the means by which the physician acquires new knowledge are varied. Professional journals, advertising, scientific meetings and courses, curbstone consultations, and the daily solving of clinical problems all contribute continously, albeit some what sporadically, to continuing education. Recently, more attention has been paid to the formal aspect of this process, and "postgraduate" or "continuing" education has become a discrete phase of medical education.

Accordingly, we offer the following listing of professional meetings and postgraduate courses. Beyond the more detailed descriptions of courses held in Indiana, we have compiled a listing of courses to be held in neighboring states during the coming three months, and this listing will be updated each month. (This material is compiled from the August 3, 1970, issue of JAMA.) We hope this service will be of aid to the physician in his Lifetime of Learning.

POSTGRADUATE COURSES IN INDIANA

The Changing Family — the Challenge of 20th Century Medicine and Psychiatry

November 18, 1970 — Indianapolis

Today we witness a growing disparity—a loss of empathy—between the generations; seniority no longer stands a respected attribute. Our young are impatient, restless and worried; they act as though hypnotized by the moment at hand, lacking a compelling vision. However, it is not ours merely to criticize, to condemn, to censor, because the attitudes of youth painfully reflect the more agonizing dilemmas of our own society. Where, then, do we turn for solutions?

A symposium on these pervasive issues is, indeed, timely, for it addresses itself to controversies presently sweeping our nation. Accordingly, we must seek deeper understanding of basic human behavior in order to close those gaps which have alienated man in his own milieu. For every physician, himself a parent and scholar, this course promises to be a memorably stimulating and enlightening experience.

Obstetrics and Gynecology

November 30—December 1, 1970 — Indianapolis

The first day of this two-day course centers on Obstetrics and Perinatology; specific topics include: intrauterine growth retardation, newer technics for assessment of fetal maturity and management of high-risk pregnancies. Guest speakers: Dr. Thomas K. Oliver, Jr., Chairman, Department of Pediatrics, University of Pittsburgh; Dr. Edgar Makowski, Professor, Department of Obstetrics-Gynecology, University of Colorado. Dr. Robert Cleary, Associate Professor, Department of Obstetrics-Gynecology, Indiana University School of Medicine, will also speak.

The second day attention turns to Gynecological Malignancies and Surgical Problems. Guest speakers: Dr. James Merrill, Chairman, Department of Obstetrics-Gynecology, University of Oklahoma; Dr. J. W. Roddick, Jr., Professor, Department of Obstetrics-Gynecology, University of Kentucky. Dr. Paul Morrow, Assistant Professor, Department of Obstetrics-Gynecology, Indiana University School of Medicine, will also speak.

Common Neurological Problems

December 16, 1970 — Indianapolis

This course outlines basic principles of management of the neurological patient. The morning session is devoted to common neurological symptoms and signs: headache, dizziness, paresthesias, gait disturbances and mental symptoms. The afternoon session turns to management of dyslexia, epilepsy, parkinsonism and cerebrovascular disease.

INDIANA

March

Indianapolis

Electrocardiography for Physicians—22nd Annual Course
3/3-5/71

Common Endocrine and Metabolic Problems
3/17/71

Anatomical and Clinical Otolaryngology—56th Annual Course
3/28/71 to 4/9/71

April

Plymouth

Psychiatric Problems in General Practice
4/7/71

Indianapolis

Contemporary Clinical Pathology and the Referral Facility
4/21/71

Lafayette

A Symposium on Trauma Emergency Care
4/22/71

May

Indianapolis

Sixth Annual Indiana Multidisciplinary Child Care Conference
5/5-6/71

June

Indianapolis

Emergency Medical Care
6/2/71

Membrane-Bound Enzymes
6/9, 10, 11/71

November

ILLINOIS

Belleville

Practical Management of Pulmonary Disease
11/16/70 to 11/18/70

Chicago

Special Review Course in Orthopedics
11/16/70 to 11/21/70

Bronchoscopy
11/9/70 to 11/13/70

Angiography
11/10/70 to 11/13/70

Blood-Vessel Surgery
11/2/70 to 11/6/70

Specialty Review Course in General Surgery, Part II
11/30/70 to 12/11/70

Obstetrics and Gynecology
11/16/70 to 11/20/70

One-Week Course in Obstetrics
11/16/70 to 11/20/70

Surgical & Radiation Therapy of Gynecological Malignancies
11/30/70 to 12/4/70

One-Week Intensive Course in Pediatrics
11/30/70 to 12/4/70

Radiology-Refresher Courses
11/29/70 to 12/4/70

Course II-Regional Anesthesia & Therapeutic Nerve Blocking
11/16/70 to 11/20/70

Specialty Review Course for Family Practice
11/2/70 to 11/13/70

Myocardial Infarction and Its Complications
11/3/70 to 11/5/70

Internal Medicine
11/9/70 to 11/13/70

Specialty Review Course in Internal Medicine Part II
11/16/70 to 11/21/70

Advances in Medicine
11/30/70 to 12/4/70

Urology for the General Practitioner
11/19/70 to 11/20/70

Scientific Assembly; Interstate Postgraduate Medical Association
11/2/70 to 11/5/70

Urbana

Carle Foundation Day Lecture Series
11/4/70

IOWA

Des Moines

22nd Annual Meeting and Scientific Assembly
11/2/70 to 11/3/70

Iowa City

In-House Conference for Practitioners
11/20/70 to 11/21/70

Sports Medicine
11/20/70 to 11/21/70

MICHIGAN

Ann Arbor

PAS and MAP Tutorial Session
11/4/70 to 11/5/70
11/18/70 to 11/19/70

Detroit

Symposium on Sex Education for the Practicing Physician
11/13/70 to 11/14/70

Supportive Care of the Surgical Patient
11/23/70 to 11/24/70

MINNESOTA

Minneapolis

General Orthopedics
11/16/70 to 11/18/70

Rochester

Clinical Reviews
11/2/70 to 11/4/70

OHIO

Akron

Visiting Professor Program
11/19/70 to 11/20/70

Cincinnati

Heat Stress-Evaluation and Control
11/2/70 to 11/6/70

Cleveland

Methods in Lipid Chemistry
11/5/70 to 11/6/70

Paternity Exclusion by Laboratory Methods
11/12/70 to 11/13/70

New Horizons in Reproductive Physiology & Pathology
11/11/70

Introductory Course in Nuclear Medicine for Physicians
11/9/70 to 11/14/70

Biomechanics
11/9/70 to 11/13/70

Diagnostic Procedures
11/11/70 to 11/12/70

Columbus

Neurology Conference
11/20/70

Ob-Gyn Conference
11/4/70

Eye Conference
11/9/70 to 11/10/70

Teaching Skill Workshop
11/1/70

WISCONSIN

Madison

Hospital Administrators-Trustees-Medical Staff Conference
11/12/70

Kidney Foundation
11/20/70 to 11/21/70

Milwaukee

Urologic Radiology
11/70

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CLINICAL CONVENTION
Date Nov. 29-Dec. 2, 1970
Place Boston, Mass.

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA STATE ASSOCIATION OF MEDICAL ASSISTANTS
Date April 23-25, 1971
Place LaSalle Motor Inn, South Bend

INDIANA ACADEMY OF GENERAL PRACTICE
Date April 20-22, 1971
Place Indianapolis Hilton

INDIANA PSYCHIATRIC SOCIETY
Date Second Wednesday of September, November, January, February, March and April
Place For time and place, inquire Wesley A. Kissel, M.D., 1815 N. Capitol Ave., Indianapolis 46202

INDIANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS
Date May 12-13, 1971
Place Indianapolis Stouffer Inn

INDIANA PUBLIC HEALTH ASSOCIATION
Date April 20-22, 1971
Place Indianapolis Stouffer Inn

INDIANA ROENTGEN SOCIETY
Date March 14, 1971
Place Holiday Inn East, Indianapolis

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 4-6, 1971
Place French Lick Sheraton, French Lick

INDIANA ASSOCIATION OF PATHOLOGISTS
Date December 5, 1970
Place Indianapolis Motor Speedway Motel, Indianapolis

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FUTURE MEETINGS, SEMINARS, COURSES

Southern Medical Association Meets November 16-19

Members of ISMA are invited to attend the 64th Annual Meeting of the Southern Medical Association from November 16 to 19 in Dallas. There will be no registration fee. Scientific sessions, panel discussions, and symposia will all be directed to medical subjects of general interest.

Chicago Schedules Diabetes Symposium

The Diabetes Association of Greater Chicago will conduct its Annual Symposium on Diabetes Mellitus at Holiday Inn, 644 N. Lake Shore Drive, Chicago, on Friday, November 20. Registration will begin at 8:30 A.M. The program will be devoted to "The Current Status of Sulfonylureas in the Treatment of Diabetes." There will also be a series of workshops in small groups for special problems and questions from the audience. The Woodyatt Memorial Lecture will be delivered in the afternoon. The fee for non-members is $10, except for medical students and resident house staff members for whom the enrollment is free. Inquiries may be addressed to the Association at 620 N. Michigan Ave., Chicago, 60611.

Laryngology, Bronchoesophagology Postgraduate Course Announced

The Department of Otolaryngology of the Eye and Ear Infirmary of the University of Illinois Hospital and the Abraham Lincoln School of Medicine of the College of Medicine, University of Illinois at the Medical Center, will conduct a postgraduate course in Laryngology and Bronchoesophagology from March 15 through 26, 1971. This course is limited to fifteen physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of other Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, University of Illinois at the Medical Center, Postoffice Box 6998, Chicago, Ill. 60680.

Ophthalmology Course Scheduled at Cleveland

The Cleveland Clinic will conduct a postgraduate course in Ophthalmology on December 9 and 10. The fee is $60. Interns and residents will pay $30. To register write The Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland, 44106. ◄

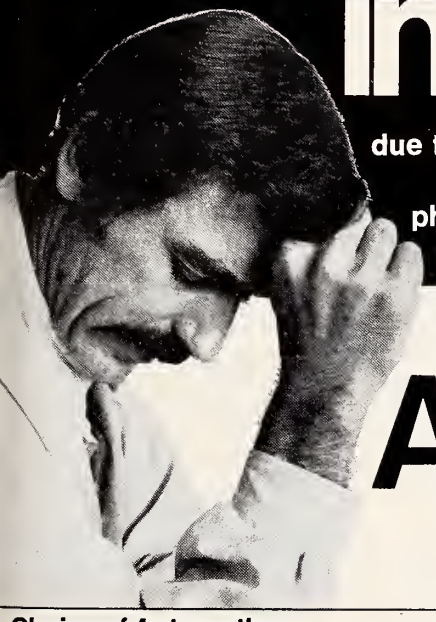
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Thiamine HCL .....10 mg.
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Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
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Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

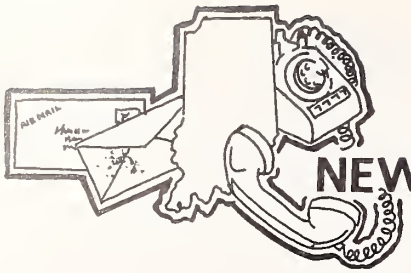
Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

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Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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NEWS NOTES

Dr H. B. Turner Honored On Fiftieth Anniversary

An open house at the Freeman-Greene County Hospital was one of the events held recently in honor of the 50th anniversary of **Dr. H. B. Turner's** graduation from medical school.

A resident of Bloomfield, he has practiced in that area since his graduation from the University of Louisville Medical School with the exception of brief stays in Glencoe, Ky., and Owensburg.

Neurosurgery Program Given

A program on neurosurgery was given by **Dr. Charles Goodell, Muncie,** at a recent meeting of the Eastern Indiana Association of Operating Room Nurses at Ball Hospital, Muncie. Registered nurses from hospitals at Peru, Wabash, Marion, Hartford City, Anderson and Kokomo attended the meeting.

Radiologist Added to Staff

DR. ANASTACIO C. NG had just become associated with the Methodist Hospital Radiologic Group in Indianapolis. Dr. Ng did graduate work in radiology at Cook County Hospital and the Mallincrodt Institute of Radiology in St. Louis. He is also Associate Professor of Radiology at Indiana University School of Medicine. The Methodist Hospital Radiologic Group now has 10 members. In addition to Dr. Ng, the members are Drs. Patrick A. Dolan, John F. Dillon, Robert E. Gerth, Augustin M. Ruiz, Joseph M. Gilson, Malcolm D. Long, George B. Pratt, William A. Tosick and Eugene D. Van Hove.

Receives "Golden Apple Award"

House staff members at St. Joseph Hospital, South Bend, recently presented **Dr. Bernard J. Dolezal, South Bend,** with the "Golden Apple Award" for "accomplishments and outstanding contributions by a staff physician."

Speaks on Diabetes

Dr. A. S. Ridolfo, senior physician in the clinical research division of Lilly Laboratory at Marion County General Hospital, was guest speaker for the annual meeting of the Howard County Diabetes Association in Kokomo.

Dr. Norris Honored

The Distinguished Eagle Scout Award was presented to **Dr. Max S. Norris, Indianapolis,** at the annual business meeting of the Central Indiana Council, Boy Scouts of America. Dr. Norris served as president of the Council for two years. The presentation was made by A. F. "Bud" Hook.

Speaks to Family Life Clinic

Approximately 100 persons attended the family life clinic sponsored recently by the Adams County Mental Health Association and heard **Dr. Nathan L. Salon, Fort Wayne,** speak on the retirement years.

Four Honored for 25 Years of Service

Four physicians who have served on the staff of Elkhart General Hospital for 25 years or more were presented certificates of recognition for their long service recently.

Honored were **Dr. Irving Mishkin** and **Robert L. Rouen, Elkhart,** and **Drs. Forest Kendall** and **Ephraim L. Fosbrink, Nappanee.**

Mental Health Speaker

Dr. Durward W. Paris, Kokomo, was the featured speaker at a Clinton County Mental Health Association dinner meeting recently.

Four Attend AAPS Meeting

Drs. F. J. Babb of Lafayette, **Hugh S. Ramsey** of Bloomington, **Jack E. Shields** of Brownstown and **Jack M. Walker** of Muncie represented Indiana as delegates to the Association of American Physicians and Surgeons at its annual meeting recently in Richmond, Va.

Dr. Bowers to Vietnam

For the fifth time, **Dr. C. Richard Bowers, Anderson,** has gone to Vietnam to work for several months in a civilian hospital.

At a farewell party for Dr. Bowers at St. John's Hospital, Sister Mary, administrator, presented him with a check for more than $500 contributed by hospital employees, volunteer workers, nursing students and his fellow physicians for use by the hospital in Vietnam.

Dr. Ferry Receives Citation

Dr. John L. Ferry, Whiting, who has served on the board of the Lake County Mental Health Clinic for 17 years, was honored recently when he resigned from the board. He was elected president of the Clinic board in 1958.

Microwave Oven Survey Discontinued

The Bureau of Radiological Health has advised General Electric that it "sees no need for further surveys of microwave ovens manufactured by the General Electric Company in view of the fact that the oven presents no significant health problem."

The Bureau and the company recently conducted a joint survey of General Electric microwave ovens that have been in use for varying lengths of time in Detroit. The data compiled in Detroit confirmed findings that the company made in separate surveys it had conducted earlier in Los Angeles, Chicago, and New York.

Dr. Bennett Speaks

Dr. Ivan F. Bennett, Indianapolis, spoke recently at the Indiana Boys School, Plainfield, and showed a film titled "Students Look at Drugs."

Two South Bend Doctors Retire from Navy Reserve

Drs. E. S. Shelley and F. W. Bussard, were honored at special retirement ceremonies held recently at the South Bend Navy Reserve Center. Both have practiced medicine in South Bend for the past 23 years and both have served 28 years in the U. S. Navy.

Dr. Bussard, who once won the 2nd Marine Division backstroke championship, is a graduate of the Underwater Swimmers School,

Key West, Fla., Deep Sea Divers School, Washington, D.C., and has been involved in underwater physiology research at the U. S. Naval Medical Research Laboratory, Submarine Base, New London, Conn. He assisted with the scuba training of 12 of the original Mercury astronauts.

Both doctors were commissioned ensigns in the Navy in 1942 and both were recalled to active duty in the Korean War.

Dr. Shelley served as medical officer on board several Navy ships and at the Navy Facility, Phoenix, Ariz. Formerly stationed at the Naval Hospital, Great Lakes, Ill., he is a former St. Joseph County coroner and is currently a deputy coroner.

Speaks at Fort Wayne

Dr. Harris Shumacker, Jr., Indianapolis, spoke to Fort Wayne physicians recently at a meeting at Parkview Hospital.

His talk on "Bypass Cardiovascular Surgery in Community Hospitals" was part of the Fort Wayne Medical Education Program's continuing education program for community physicians.

Psychiatrist Wins AMA Recognition

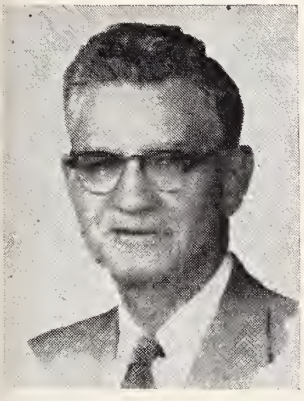
The American Medical Association Physician's Recognition Award in Continuing Medical Education has been presented to **Dr. Robert F. Green, Fort Wayne.**

A graduate of Seton Hall College, Dr. Green received his M.D. from the State University of New York and interned at Brooklyn Hospital. His residency was at Peter Bent Brigham Hospital, Boston, and Worcester State Hospital, Worcester, Mass. He is a diplomate of the National Board of Medical Examiners and of the American Board of Psychiatry and Neurology.

Marion College Speaker

Dr. C. R. Woodbury, Anderson, was one of the speakers for the second annual Marion College "Alumni College," a program for graduates, former students and friends of the college.

Theme of the three-day program was "Life or Breath," with the various speakers discussing phases of pollution. Dr. Woodbury's subject was "Pollution and the Body."



Dr. Jones Honored

Dr. Eli Sherman (Jack) Jones, Hammond, has been presented the Indiana University Distinguished Alumni Service Award.

Named to Pollution Board

Governor Edgar D. Whitcomb has re-appointed **Dr. Harry E. Klepinger,** Lafayette city health officer, to the Air Pollution Control Board.

Dr. Holliday Serves

Dr. Alfonso D. Holliday, Gary, served as chairman of the recent Lake County Health Fair which was sponsored by the Northwest Indiana United Fund.

Dr. Shaffer Renamed

The Decatur County Board of Health recently reappointed **Dr. William R. Shaffer, Greensburg,** to a four-year term as County Health Officer.

Tour Vietnam

Dr. Martin J. O'Neill, Sr., Valparaiso, accompanied Congressman Earl F. Landgrebe, the Rev. Roger Landgrebe and Brig. Gen. (Ret.) John O. Bradshaw of Lafayette on a three-week tour of the Middle East and Indo-China recently. A stop in Saigon was scheduled.

Another Valparaiso physician, **Dr. Leonard J. Green,** was granted a three-month leave of absence by the Porter Memorial Hospital trustees, during which time he will visit Vietnam and Cambodia.

Dr. Bowen Speaks

Howard County's newly organized Taxpayers Association heard a talk by **Dr. Otis R. Bowen, Bremen,** at a meeting in the courthouse at Kokomo recently. Dr. Bowen has been elected to a three-year term on the board of trustees of Ancilla College, Donaldson.

Health Center Named For Dr. Charles Keever

A two-story, $235,000 health center was recently dedicated at the Indiana School for the Blind, 7725 N. College Avenue, Indianapolis.

Guest of honor at the dedication was **Dr. Charles Keever,** Indianapolis, in whose honor the building was named. He served as the school's physician more than 15 years.

The second story of the building has six classrooms and the health facilities are located on the first floor.

Pneumoconiosis Film Available

A new 20-minute 16 mm movie film is available to medical groups. It explains the new law for control of pneumoconiosis and discusses chest x-rays and other features of the program. It is designed for showing to physicians, hospital staffs and other medical groups. It is on free loan from American College of Radiology, 20 N. Wacker Drive, Chicago, 60606.

Free Film on Drugs Offered

Eli Lilly has a new 16-mm, 26-minute, color, sound, instructional movie, "Students Look at Drugs," which is on free loan for showing to PTA's, civic groups, high school students and similar audiences. It portrays a group of high school and college students in an "unstructured" interview with **Dr. Ivan F. Bennett,** during which the students talk about drugs. It may be obtained by contacting any Lilly representative.

Re-elected to Membership By General Practice Academy

Announcement has been made that the following physicians have been re-elected to the American Academy of General Practice:

Drs. Paul F. Zwerner, Terre Haute; Frank B. Bard, Crothersville; George M. Wolverton, Clarksville; Marshall E. Stine, Bremen; V. K. Pancost and **Dale R. South, Jr., Elkhart; Howard T. Hammel, Bedford; William R. Wells, Princeton; James H. Tower, Shelbyville,** and **John Patrick Turner, Goshen.**

John Shaw Billings History of Medicine Society Announces Meetings

The John Shaw Billings History of Medicine Society of Indiana University School of Medicine announces a series of monthly lectures. Each program will be presented in Room M-124 in the Student Union Building at 8 P.M. on the date announced. At 7 P.M. on each lecture night a social hour will be held in the same room at which time medical students will become acquainted with the guest lecturer and members of the faculty. All interested physicians are invited to attend.

November 18, 1970 OWEN H. WANGENSTEEN, M.D., Regents Professor, Department of Surgery, University of Minnesota, Minneapolis, Minnesota
Some Durable Contributions of American Surgeons to Surgery's Progress During the Past Two Centuries

February 10, 1971 J. HARVEY YOUNG, Ph.D., Professor, Department of History, Emory University, Atlanta, Georgia
Quackery

March 10, 1971 ROBERT P. HUDSON, M.D., Chairman and Professor, History of Medicine and Philosophy, University of Kansas Medical School, Kansas City, Kan.
History of American Medical Education

April 14, 1971 GEORGE ROSEN, M.D., Professor of the History Medicine and Epidemiology and Public Health, Yale University School of Medicine, New Haven, Conn.
The Neighborhood Health Center Movement — Its Rise and Fall

May 12, 1971 ROBERT SPARKMAN, M.D.; Chief, Department of General Surgery, Baylor University Medical Center, Dallas, Texas
A Day to Remember

Diplomates Named

Three Indiana physicians have been certified as diplomates of the American Board of Family Practice. They are: **Drs. Donald Hall, Petersburg; William E. Fitzkee, Albion,** and **Richard P. Miethke, Anderson.**

Trauma Training Awards Made

Dr. John Suelzer, director of ambulance services at Marion County General Hospital, awarded Trauma Care Training Certificates to 76 men who were enrolled in the Hospital's recent trauma training program. All were employed in various central Indiana municipal departments, coming from Anderson, Muncie, Greenwood and Indianapolis.

Graduation ceremonies opened with a brief address by **Dr. Arvine G. Popplewell,** director of hospitals.

Cancer Signs Told

Tipton County extension homemakers club project leaders heard a talk by **Dr. Albert E. Stouder,** Kempton, recently. His subject was cancer.

Serves as School Board President

Dr. Russell Baskett, Jonesboro, was re-elected president of the Mississinewa school board recently. He has served on the board for two years and was re-elected to another four-year term.

Honored at Evansville

Fifty persons who have lived, worked or studied in Indiana were recognized for outstanding achievements with the presentation of Medals of Honor from the University of Evansville at a recent ceremony.

Among those honored in commemoration of the 50th anniversary of the university's founding was **Dr. Harris B. Shumacker, Jr., Indianapolis.**

Plastic Surgery Topic

Dr. Dwayne Hull spoke to the Sertoma Breakfast Club at Fort Wayne recently. He discussed plastic surgery.

Elected Rotary President

New president of the Columbia City Rotary Club is **Dr. Warren L. Niccum.** A pediatrician, Dr. Niccum is also serving as Whitley County coroner.

Film on Smoking Problems Offered

A medical film "Fair Warning," designed to provide information that will assist the health professionals in dealing with patients' smoking problems, is available on free loan from the National Medical Audiovisual Center. The film is 16 mm, with sound and color and runs for 28 minutes. Audiences should be limited to physicians, dentists, nurses and other health professionals with patient care responsibilities. The address for the Center is Station K, Atlanta, Georgia 30324.

Attend World Conference

Lester D. Bibler, M.D., and **A. Alan Fischer, M.D.,** of Indianapolis attended the Fourth World Conference on General Practice in Chicago August 12-15 as official observers.

Dr. Sorrells Named

Dr. George W. Sorrells, Indianapolis, is one of 600 physicians selected by the American Academy of Pediatrics to evaluate the medical aspects of the Head Start program in nearly 2,000 communities throughout the United States and its holdings.

Dr. Peck Promoted



F. Bruce Peck, Jr., M.D., Indianapolis, has been promoted from senior physician to director of medical plans and regulatory affairs for Eli Lilly and Company.

He attended Indiana University and received his medical degree from Jefferson Medical College in 1952.

Dr. Peck has been associated with the Lilly company since 1954 when he joined the firm as a resident physician in the Lilly Clinic at Marion County General Hospital. In 1962 he was promoted to senior physician.

Dr. Glueck Receives Grant

Dr. Charles J. Glueck, University of Cincinnati Medical Center, has received a three-year grant from the National Institute of Child Health and Human Development to study the effects of synthetic steroids with progestational and anabolic compounds in patients who have pre-existing elevations of plasma triglycerides. To date he has studied over 75 families from Ohio, Kentucky and Indiana. The results in lowering the plasma levels by treatment with progestational compounds has been encouraging.

Dr. Wing Named

Dr. Herman Wing, formerly of Gary, and now in Chicago, has been announced as a member of the Board of Governors of the American College of Legal Medicine.

Dr. Russell Honored By AMA for Research

Dr. Henry T. Russell, Lafayette, director of the St. Elizabeth Hospital medical laboratories, has been presented with the Physician's Recognition Award by the American Medical Association for his research work in bionucleonics.

The requirements for the award were fulfilled with postgraduate work at Purdue University. The topic of Dr. Russell's research was the development of a radioimmuno assay technic using peripheral blood leukocytes.

Dr. Russell is a fellow of the American Society of Clinical Pathologists, the American College of Pathology and International Academy of Pathology. He is a member of the Society of Nuclear Medicine and an associate professor at Purdue in the department of pharmacy and toxicology.

He also serves as vice president of the Greater Lafayette Chamber of Commerce.

Medical Assistants to Meet

The American Association of Medical Assistants meets in Des Moines for their 14th annual convention on October 28 to 31. Ninety-two medical assistants will be honored for having obtained certification during 1970. Miss Elaine J. Klimek of Portage will be one of the 92 so honored. A new feature of the program will be workshops for those who wish to acquire additional education in medical assistant work with specialists. **Dr. Lowell Thomas,** Indianapolis, will conduct the workshop in orthopedics. The AAMA now has a national membership of 13,000 medical office assistants, including secretaries, technicians, nurses and others who work under the direct supervision of a physician.

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Gary Methodist Hospital Appoints Dr. Lytwakiwsky

Dr. Anatol Lytwakiwsky has been named Medical Director of the Rehabilitation Center and Chief of the Physical Medicine and Rehabilitation Division of the Medical Staff at Gary Methodist Hospital.

The Rehabilitation Center, now under construction, is scheduled for completion early next year. It will be the first center in Northern Indiana with comprehensive rehabilitation services for inpatients and outpatients.

Fire Protection Books Available

Four fire protection books, each of interest to hospitals, are announced for sale by the National Fire Protection Association. "Standard for the Use of Inhalation Anesthetics (Flammable and Nonflammable)" has 84 pages and is priced at $1.50. "Standard for Hyperbaric Facilities" contains 52 pages and sells for $1.00. "Standard for Essential Electrical Systems for Hospitals" is 36 pages long and sells for 75 cents. "Safety Standard for Hospital Laboratories" has 24 pages and comes at 75 cents. Write the Association at 60 Batterymarch St., Boston 02110.

Assumes Command

Col. H. Haskell Ziperman, graduate of Indiana University School of Medicine in 1941 and a member of the Medical Corps of the U. S. Army since then, has assumed command of Martin Army Hospital at Fort Benning, Georgia. Col. Ziperman's most recent tour of duty was as Health Director of the Canal Zone Government.

Pamphlet on Alcoholism Offered

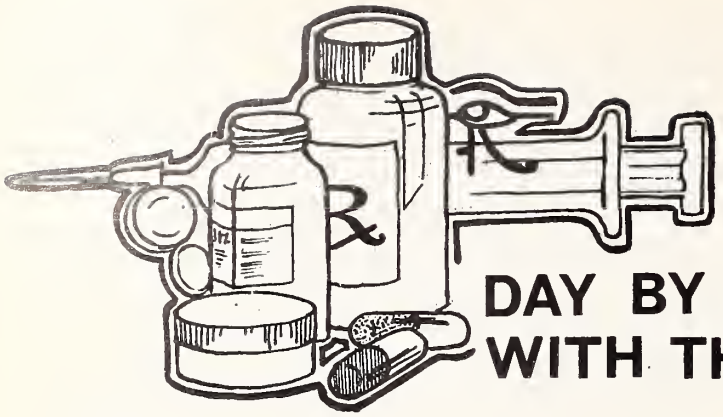
"How to Help the Alcoholic" is the title of Public Affairs Pamphlet No. 452. It is written as an aid to families and employers in the task of alleviating the effects of alcoholism in a relative or employee. The pamphlet is obtainable at a cost of 25 cents per copy by writing Public Affairs Committee, 381 Park Avenue South, New York City 10016. Discounts are available for quantity orders.

Take Advisor Posts

Five Fort Wayne physicians have been appointed to an advisory committee of the Allen-Wells Red Cross chapter. Committee members are: **Drs. Robert J. Ball, John E. Krueger, Luman Bromley, James Luckey and Lewis Knight.** ◄

Indiana Medical Foundation

The Indiana Medical Foundation was organized to furnish support for the educational activities of the Indiana State Medical Association. These activities include programs for continuing education and the scientific publications of *The Journal.* Contributions made to the foundation are deductible by donors in accordance with the Internal Revenue Code. Bequests, legacies and gifts are deductible for federal estate and gift tax purposes. Memorial contributions made to the foundation will be formally recorded and acknowledgment will be sent to the family. Gifts, bequests, and memorial contributions may be mailed to the foundation at 3935 N. Meridian St., Indianapolis 46208.



DAY BY DAY WITH THE F.D.A.

"Blosser's Asthma Cigarettes" are being seized because the package does not bear the legend "Caution: Federal Law Prohibits Dispensing Without Prescription". The cigarettes are classified as a prescription item since they contain jimson weed (stramonium).

* * *

One hears a lot of complaints about castor oil but the FDA was interested in the case of a man who required hospitalization because his castor oil was contaminated with camphor. The manufacturer was charged with faulty processing practices.

* * *

French cheese merchants send technicians to New York to study the method of detecting and measuring pesticide residues. World-wide pesticide problems prompt the testing of foods prior to intercontinental shipping.

* * *

The cleanup after Hurricane Camille involved the destruction of $3.5 million worth of food and drugs, damaged beyond salvage. This figure does not include the much larger value of foods and drugs which were destroyed outright by the storm and were not subject to salvage operations.

* * *

"Cancer serums" are dangerous because they are totally ineffective and tend to postpone or avoid possible effective treatment. However, the FDA in Detroit last year discovered that the Hett serum which was being bootlegged from Canada was heavily contaminated with bacteria; high counts of pseudomonas, proteus and streptococci. At least one patient died as a result.

* * *

Coho salmon and other fish from Lake Michigan are running high pesticide residues. DDT and dieldrin have been recovered from fresh and smoked fish in quantities almost twice as high as the allowable tolerance level. Several interstate shipments have been seized and destroyed.

* * *

The FDA monitors childs' toys and refuses those found to be dangerous. Several varieties of toy dogs, imported from Japan for Chistmas trade last year, were found to contain flammable stuffing. Attempts to render them fireproof were unsuccessful. They were eliminated from sale by provisions of the Federal Hazardous Substances Act.

* * *

The Indiana Bureau of Food and Drugs has a Hazardous Products Section which surveys and monitors the Poison Information Centers of the state. Two hospitals elected to discontinue their centers last year, but there are still 31 active centers, including the one at the Hazardous Products Section which coordinates the state program.

* * *

Custard still makes a good culture medium. In Chicago 525 cases of eclairs, worth $3700, were destroyed when found contaminated with E. coli and staphylococci.

* * *

At the Detroit Zoo last winter the mystery of high mortality rates for young birds of the South American rhea family was solved by finding 15 parts per million of DDT and its analogs in unhatched rhea eggs.

* * *

A consumer in Long Beach, California, was taking an antialcoholism drug as an aid in kicking the habit. He was also taking a herbal concoction called "Bio Strath Drops" as a tonic. A violent illness ensued, due to the fact that the drops were mostly alcohol, although the label did not list it as such. FDA removed the drops from the market for failure to list the ingredients and give special dietary information.

* * *

Giant edible clams, called geoducks and pronounced "goceyducks," have been considered as scarce for many years. Harvesting geoducks has been controlled because of the limited supply. Now the supply is ample—possible annual harvest is estimated at 40 million "ducks." They average three pounds and may go up to ten pounds. And that is a lot of chowder.

* * *

Liquefied petroleum gas contaminated with Freon is a new hazard. When the mixture is burned, phosgene is formed. Fortunately the lethal combination was discovered before any of the LP gas was on the market. ◄

The actions of the official Tincture and Extract of Belladonna result chiefly from their Atropine content . . . conclude Goodman and Gilman

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS
3rd Edition, page 522



ANTROCOL®

Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to even absorption.



Each tablet or capsule contains: Atropine sulfate, 0.324 mg.; Phenobarbital, 16 mg. (may be habit forming); Bensulfoid, 65 mg. (see white section PDR). The atropine content of Antrocol is the maximum amount the average patient can take at six hour intervals over long periods with comfort.

SUPPLIED
Tablet in bottles of 100, 500 and 5000
Capsule in bottles of 100, 500 and 1000

Caution: Federal law prohibits dispensing without prescription.

PRESCRIBING INFORMATION

Contraindicated in glaucoma. Use cautiously in prostatic hypertrophy. Side-effects of toxic dose of atropine: flushing, dryness of mouth, cycloplegia, tachycardia and urinary retention.

DOSAGE: One tablet or capsule after each meal to correct emotional stress and normalize gastric secretions. In treating peptic ulcer, doses at regular intervals up to eight (8) tablets or capsules per day to provide the proper gastric titer for healing. After ulcer has healed, one tablet or capsule after each meal to maintain a titer unfavorable to recurrence.

Clinical supply available to physicians.

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Roche announces

Efudex®

(fluorouracil) cream/solution

for the treatment of solar/actinic keratoses... a topical alternative to conventional therapy

Fluorouracil—the Roche contribution

In 1962, Roche Laboratories introduced Fluorouracil Roche® (5-fluorouracil). Early clinical work with this drug suggested that it possessed a selective cytotoxic activity when applied topically to certain kinds of lesions. Based on this work and years of clinical trials, a standardized form of topical fluorouracil can now be recommended for treatment of multiple solar or actinic keratoses.

Efudex®(fluorouracil)—a new alternative to conventional therapy

Efudex presents the physician with a topical alternative to surgery in the treatment of solar or actinic keratoses. It is effective, comparatively inexpensive and especially well-suited for treatment of multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

Highly effective on first and later applications

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When lesions did recur or new ones appeared, repeated courses of Efudex therapy proved effective.*

1/22/68—Treatment with 5% 5-FU cream commences. Patient K.L. showing widespread but mild solar keratoses (also known as actinic keratoses).



2/2/68—After 11 days of treatment. Erythema is seen at site of keratoses. In addition, numerous lesions not apparent prior to therapy have become manifest by sharply defined reactions. Intervening skin, also treated, shows no response to therapy.

2/19/69—One year after cessation of therapy. Skin appears clear with no evidence of scarring. Examination reveals lack of recurrence or the formation of new lesions.



Predictable sequence of therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of the keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two to three months before gradually receding.

Selective—with a high degree of safety

Despite the temporary unsightliness and discomfort of the inflammatory episode, Efudex is, in general, more readily tolerated than surgery. Clinical work shows the intense inflammatory response to be limited to the area of the lesion. Normal skin is not similarly affected. Another measure of Efudex safety: systemic absorption of topical fluorouracil was insignificant, indicating a low risk of systemic toxicity.*

Two strengths—two convenient dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, there are two important considerations. First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

2% and 5% Solutions; 5% Cream Applied twice daily—resolves solar or actinic keratoses.

new Efudex® (fluorouracil) cream/solution



For full prescribing information, please see the following page.

Roche introduces

Efudex®

(fluorouracil) cream/solution the new standardized topical for solar/actinic keratoses

Description: Efudex solutions and cream are topical preparations containing the fluorinated pyrimidine 5-fluorouracil, an antineoplastic antimetabolite.

Efudex Solution consists of 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris-(hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Actions: There is evidence that the metabolism of fluorouracil in the anabolic pathway blocks the methylation reaction of deoxyuridylic acid to thymidylic acid. In this fashion fluorouracil interferes with the synthesis of deoxyribonucleic acid (DNA) and to a lesser extent inhibits the formation of ribonucleic acid (RNA). Since DNA and RNA are essential for cell division and growth, the effect of fluorouracil may be to create a thymine deficiency which provokes unbalanced growth and death of the cell. The effects of DNA and RNA deprivation are most marked on those cells which grow more rapidly and which take up fluorouracil at a more rapid pace. The catabolic metabolism of fluorouracil results in degradative products (*e.g.*, CO_2, urea, α-fluoro-β-alanine) which are inactive.

Studies in man with topical application of ^{14}C-labeled Efudex demonstrated insignificant absorption as measured by ^{14}C content of plasma, urine and respiratory CO_2.

Indications: Efudex is recommended for the topical treatment of multiple actinic or solar keratoses.

Contraindications: Efudex is contraindicated in patients with known hypersensitivity to any of its components.

Warnings: If an occlusive dressing is used, there may be an increase in the incidence of inflammatory reactions in the adjacent normal skin.

Prolonged exposure to ultraviolet rays should be avoided while under treatment with Efudex because the intensity of the reaction may be increased.

Usage in Pregnancy: Safety for use in pregnancy has not been established.

Precautions: If Efudex is applied with the fingers, the hands should be washed immediately afterward. Efudex should be applied with care near the eyes, nose and mouth. To rule out the presence of a frank neoplasm, a biopsy should be made of those areas failing to respond to treatment or recurring after treatment.

Adverse Reactions: The most frequently encountered local reactions were pain, pruritus, hyperpigmentation and burning at the site of application. Other local reactions included dermatitis, scarring, soreness and tenderness.

Also reported were insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity and lacrimation.

Laboratory abnormalities reported were leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Efudex should be applied twice daily with a nonmetal applicator or suitable glove in an amount of the solution or cream sufficient to cover the lesion. When Efudex is applied to a lesion, a response occurs with the following sequence: erythema, usually followed by vesiculation, erosion, ulceration, necrosis and epithelization. The lower frequency and intensity of activity in adjacent normal skin indicate a selective cytotoxic property. Medication should be continued until the inflammatory reaction reaches the erosion, necrosis and ulceration stage, at which time use of the drug should be terminated. The usual duration of therapy is from 2 to 4 weeks. Complete healing of the lesion may not be evident for 1 to 2 months following cessation of Efudex therapy.

How Supplied: Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Clinical Studies: The effectiveness of the three preparations as determined by complete involution of solar keratoses was: 2% Solution, 77% of 282 lesions; 5% Solution, 88% of 202 lesions; and 5% Cream, 85% of 189 lesions. In those lesions where complete involution followed treatment, the rate of possible recurrences observed clinically at periods up to 12 months or more was: 2% Solution, 4.6% of 218 lesions; 5% Solution, 1.7% of 177 lesions; and 5% Cream, 5.6% of 160 lesions. Because of the toxic potential of fluorouracil, some physicians preferred to use the 2% solution when large areas were to be treated. Approximately 30% of the lesions required treatment for two weeks or less; approximately 78% required four weeks or less for adequate treatment.

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INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—September 1970

Disease	Aug. 1970	July 1970	June 1970	Aug. 1969	Aug. 1968
Animal Bites	1175	1470	1313	1221	1177
Chickenpox	20	36	111	41	50
Conjunctivitis	125	157	142	122	94
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	55	26	25	21	50
Gonorrhea	753	824	697	685	640
Impetigo	190	171	95	189	211
Infectious Hepatitis	52	45	46	21	49
Infectious Mononucleosis	29	44	56	20	31
Influenza	338	206	321	272	191
Measles					
Rubeola	5	22	16	1	40
Rubella	60	77	117	38	58
Meningococcic Meningitis	3	0	1	2	3
Meningitis, Other	2	3	0	4	5
Mumps	63	103	191	93	78
Pertussis (Whooping Cough)	14	15	13	3	28
Pneumonia	220	209	275	137	90
Poliomyelitis	0	0	0	0	0
Syphilis					
Primary & Secondary	34	38	35	27	35
All Other Syphilis	114	170	150	81	145
Tinea Capitis	5	1	7	6	6
Tuberculosis (Active)	70	102	73	82	61
Streptococcal Infections	418	455	460	328	438



BREAKUP—symbol of the impact of emotional stress. But when the stress exceeds transient rage or depression—and settles into a chronic mixed anxiety depression state—combined tranquilizer-antidepressant therapy could be indicated.



FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

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Containing perphenazine and amitriptyline HCl

For prescribing information, including indications, contraindications, warnings, precautions, and side effects, please see following page.



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TRIAVIL®2-10: Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; pregnancy; and in patients with known hypersensitivity to phenothiazines or amitriptyline. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least two weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response. Do not give concomitantly with guanethidine or similarly acting compounds since it may block the antihypertensive effect.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be increased.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Use with caution in patients with glaucoma and those with problems of urinary retention. Perphenazine can lower the convulsive threshold in susceptible individuals. It should be given with caution to patients with convulsive disorders. Dosage of the anticonvulsive agent may have to be increased. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

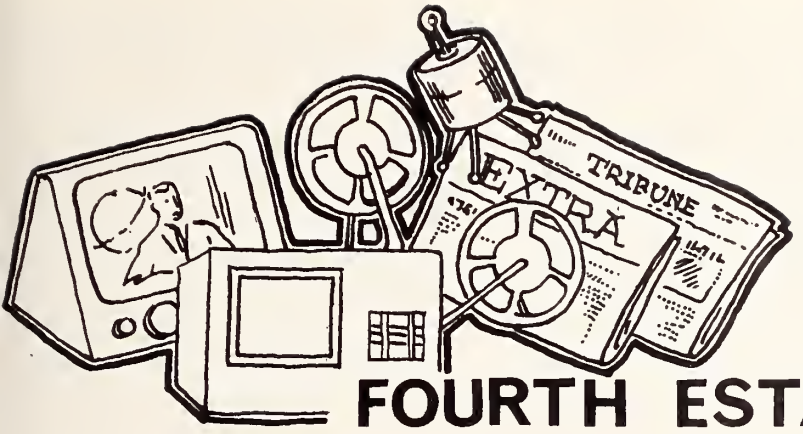
ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients who have previously exhibited severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia. Other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation. Significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypertension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; impotence; increased appetite and weight gain; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, stomatitis, blurring of vision, reversible dilatation of the urinary tract, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. Elderly patients and adolescents can often be managed on lower dosage levels.

For more detailed information, consult your MSD Representative or see the package circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD MERCK SHARP & DOHME



FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Medical Profession Faces Serious Problems

We were not really surprised when some of the community's doctors told us last week that the medical situation -- referring primarily to the shortage of family physicians — has not improved in Jay County during the last three years. If anything, it has taken a turn for the worse.

That part was no surprise because almost everyone these days has noticed how many medical people want to go into specialized fields instead of general medicine.

But we weren't fully aware of the enormity of the problem — that, for example, 80 per cent of the nation's total medical practice is now performed by MDs, but only seven per cent of the new generation of medical students is staying in the field as future replacements. It makes one wonder what will be the result if the trend continues.

Another thing: While the medical profession always seemed one of the busiest ones to us, we hadn't realized before how great the pressure can be on a small-town doctor until we talked to some of them.

Dr. William H. Cripe, for instance, now that he has taken over as fulltime anesthetist at the hospital (so that surgery can still be performed here) in addition to his regular practice, is on call literally 24 hours a day, seven days a week. The hospital's two surgeons, Dr. Ralph Schenck and Dr. James Fitzpatrick, are in virtually the same position.

Dr. Cripe may be right on another point, too, when he says that too many people today expect the best medical treatment for practically nothing, and they want it immediately. The waiting that may be encountered in local offices is nothing compared to that in larger cities, he says, so Jayland may have some advantages in that respect.

We can sympathize with the medical community and hope that efforts now being made to reverse the doctor shortage will get results before it is too late. In the meantime, Jayland residents should be more understanding of the problems their doctors face.—Mike Lewis—*Portland Commercial Review*, August 7, 1970.

Whither Social Security?

The House Ways and Means Committee has decided on a 5% increase in Social Security benefits, on top of the 15% boost voted last year. The proposal would require a boost in the wage base on which Social Security taxes are figured.

In the circumstances it surely is time for both Congress and the public to give more serious thought to where Social Security is heading, not just in the next year or so but in the more distant future.

One man who has done so is Robert J. Myers, who has served as chief actuary of the Social Security Administration for more than two decades. The relentless pressure to extend and enlarge benefits (especially in election years) causes him a great deal of concern.

As befits a career Federal official, Mr. Myers does not indulge in polemics. Yet his comments in "The Future Role of Social Security," published by the Tax Foundation, leave little doubt as to where he stands.

Mr. Myers stresses that the fundamental idea of Social Security was to provide "a basic floor of protection on which individuals can build through their own efforts." Although the benefits have been increased several times, these actions have served largely to offset the inroads of inflation.

As the Ways and Means Committee's contemplations demonstrate, there has also been continuing pressure to move from the floor-of-protection idea in the direction of benefits that would meet all the needs of all of the elderly. At the same time, of course, many persons would like to see the health-care provisions cover not just older Americans but the entire population.

To make possible a vast enlargement of benefits, the expansionists would sharply increase Social Security taxes, especially on employers, and draw heavily on general Federal revenues. While such a financing approach might work in theory, it would raise a number of questions.

For one thing, there is the question of just how much Social Security tax the public will tolerate. Already, the Tax Foundation notes, some families pay more in Social Security levies than they do in Federal income tax. Even as matters stand, younger workers often will draw less from the system than they contribute.

The notion that a disproportionate part of the burden can be shifted to employers, moreover, is in large part an illusion. Employers will pass along much of the increased cost burden to the public in higher prices. In addition, the greater burden will speed mechanization, which may be good for the economy in the long run but bad for employes who lose jobs in the short run.

Mr. Myers further remarks that the link between benefits and Social Security tax increases exerts a form of cost control, which would be lost if the system began dipping deeply into general revenues. He also fears that Social Security, if it were at all at the mercy of annual Congressional arguments over spending, might sometimes partly default on its obligations.

Even if all the financing problems could be worked out, Mr. Myers warns that the public should be aware of the effects of providing "adequate" aid for everyone. "Not only would there be the direct effect of eliminating most private sector efforts in the economic security field," he says, "But also a most significant effect on our national economy would occur.

"Private insurance and savings would be greatly reduced. This in turn would result in a shortage of investment funds for private industry. . . . Accordingly, private industry would have to turn more and more to the Government for such funds, and this could well mean increasing Governmental regulation, control, and even ownership of productive activities."

Expansionists like to argue that those who oppose their aims are simply against Social Security. At present, however, few Americans favor outright elimination of a system that plays so large a role in the retirement planning of so many Americans.

A good many citizens—Mr. Myers thinks they form a substantial majority—nonetheless want to retain the original floor-of-protection idea, meanwhile continuing to study the setup and making changes as they are found to be necessary. If the Government manages to check inflation, and then avoids future financial excess, the need for such changes would arise less often.

A moderate approach to Social Security will still leave some citizens in need, and for these the nation can and should provide reasonable welfare assistance. Any attempt to puff up Social Security to do the whole job for all Americans, whether they need the help or not, could endanger the welfare of us all.—*Wall Street Journal*, May 19, 1970. ◄

About Our Cover

A bend in the road — perhaps James Whitcomb Riley's "long highway with sunshine spread thick as butter on country bread" — was the spot photographer Henry Wood chose for this month's cover photograph. This particular scene is on State Highway 135 south of Nashville.

County, District News

Eleventh District

At the annual meeting of the Eleventh District in Wabash on September 23, Dr. Lloyd Hill of Peru was elected president and Dr. Fred Poehler of La Fontaine was re-elected secretary-treasurer. The 1971 meeting will be held at Peru.

Knox County

New officers chosen by the Knox County Medical Society when it met on June 16 were: President, Dr. J. Frank Stewart; president-elect, Dr. Malcolm S. Floyd; secretary, Dr. Ed Cantwell, and treasurer, Dr. Louie Dayson.

Owen-Monroe

Dr. Paul J. Wenzler was named president; Dr. Charles B. Emery, Jr., vice president; Dr. John Philip White, treasurer, and Dr. Glenn D. Mather, secretary of the Owen-Monroe County Medical Society at a recent meeting. Drs. Thomas O. Middleton and Courtney Seagle were chosen as delegates from Monroe County. All are from Bloomington. Dr. Robert Rose of Spencer was chosen ISMA delegate from Owen County.

Hendricks

Three new practicing physicians in the county were guests when the Hendricks County society met in July in the conference room of the County Hospital. There was a discussion of the state orientation program.

Boone

Sixteen members were present on September 1 when the Boone County society met at Witham Memorial Hospital. Resolutions to come before the ISMA annual convention were read and discussed.

Jay

Members attending the meeting of the Jay County society at the Portland Country Club on September 2 voted to change their election to May 1971 and discussed resolutions to be presented at the 121st annual convention of the Indiana State Medical Association in South Bend.

Dearborn-Ohio

Dr. Ivan T. Lindgren was welcomed as a new member of the Dearborn-Ohio County Medical Society when that group met at the Dearborn Country Club on September 3. A member of the Academy of Medicine, Cincinnati, Dr. Lindgren is also a member of the Ohio State Medical Association.

Fountain-Warren

Dr. Fae Spurlock, director of the Tippecanoe Mental Health Center, was the speaker for the September meeting of the Fountain-Warren Medical Society meeting at the Attica Hotel. Dr. At. S. Salvo was welcomed as a new member.

Tippecanoe

Four new members were admitted when the Tippecanoe County society met at The Trails on September 8. Delegates to the state convention were instructed as to 23 resolutions to be presented there. Election of new officers will take place at the next meeting, which will occur on November 10 at The Trails.

Fayette-Franklin

"Relative Value Scales" was the topic of the talk given by James Fox of the John Hancock Insurance Company when members of the Fayette-Franklin society met September 8 at the Hearthstone Rest.

Wayne-Union

The Hon. David W. Dennis (R) and Phillip Sharp (D), candidates for the Tenth District Congressional seat, discussed political issues when the Wayne-Union County Medical Society met at the Forest Hills Country Club at Richmond on September 8. Local attorneys and dentists and wives were also guests.

Marshall

Dr. Shelden Waldenstein of the Northwestern University School of Medicine gave a talk on common thyroid problems when the Marshall County group met at the Plymouth Holiday Inn on September 8. It was decided that present officers would hold office until next April and that the date of the annual election would be changed from September to April.

Vanderburgh

A film on the Indiana Lions Eye Bank was presented at the September 8 meeting of the Vanderburgh County society.

Putnam

Seventeen members of the Putnam County society heard a talk by Robert J. Amick, ISMA field secretary, when they met at the County Hospital on September 11. In addition, there was a discussion of the proposed hospital building program.

Hancock

"The Medical and Surgical Treatment of Peripheral Vascular Disease" was presented at the September 28 meeting of the Hancock County Society at the Hospitality Inn, Indianapolis, on September 28. Dr. Baron's accompanying film was shown.

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Association News

BOARD OF TRUSTEES

July 26, 1970

The Board of Trustees of the Indiana State Medical Association convened at 10:00 a.m. in the Headquarters Building with Dr. Peter R. Petrich, chairman, presiding.

Roll call showed the following:

District	Trustee	
1	Gilbert M. Wilhelmus	Absent
2	Joe Dukes	Present
3	Donald M. Kerr	Present
3	Eli Goodman (Elect)	Present
4	Robert Reid	Absent
5	Wilbert McIntosh	Absent
6	Stephen Smith	Present
7	James H. Gosman	Present
7	Dwight W. Schuster	Present
8	Richard G. Ingram	Present
9	Peter R. Petrich	Present
9	William Sholty (Elect)	Present
10	Vincent J. Santare	Present
11	Lowell J. Hillis	Present
12	William Clark	Present
13	Otis R. Bowen	Absent

District	Alternate	
1	Eugene W. Austin	Absent
2	Betty Dukes	Present
3	Elmer L. Wallace	Absent
4	Jack Shields	Present
5	Cleon Schauwecker	Absent
6	Paul M. Inlow	Present
7	John Butler	Absent
7	Joseph Kerlin	Present
8	Paul Sparks	Absent
8	Robert D. Williams (Elect)	Present
9	Lindley Wagner	Absent
10	Thomas C. Tyrrell	Present
11	James A. Harshman	Present
12	Frederic Schoen	Absent
13	G. Beach Gattman	Present

Delegates and Alternate Delegates to the AMA

Don E. Wood	Absent
Eugene Senseny	Absent
Frank H. Green	Absent
Jack Shields	Present
John S. Farquhar	Present
James A. Harshman	Present
Eugene S. Rifner	Present
Kenneth O. Neumann	Present
Patrick J. V. Corcoran	Absent
Thomas C. Tyrrell	Present

Officers:

Lowell H. Steen, Hammond, president, Present
Malcolm O. Scamahorn, Pittsboro, president-elect, Present
Lester H. Hoyt, Indianapolis, treasurer, Present
Hugh K. Thatcher, Indianapolis, assistant treasurer, Present
Frank B. Ramsey, Indianapolis, editor, *The Journal*, Present

Executive Committee:

Donald M. Kerr, Bedford, chairman, Present
Burton E. Kintner, Elkhart, member, Present

Guest:

G. O. Larson, LaPorte

Staff:

Robert J. Amick, field secretary, Present
John L. Walters, field secretary, Present
Kenneth W. Bush, administrative assistant, Present
James Waggener, executive secretary, Present

Minutes of the meeting held June 13-14 were adopted on motion with an editorial correction by Dr. Santare and taken by consent.

Reports of Officers

PRESIDENT STEEN: The Commission on Medical Education and Licensure has put forth a great deal of effort and is still in the process of studying the subject of physician's assistants. I think it imperative that the Board make a very strong recommendation and possibly report to the House that it is important that this organization assume a position of primacy with regard to physician's assistants. I believe we should take the responsibility for setting forth a criteria for the training and the background people should have to go into this training, and we should be responsible for deciding the content of the curriculum and how long the educational process should last. I further believe that we should strengthen the support and assistance of the various specialty societies which will have their own specialty assistants. If we do not take the responsibility for this, others will no doubt submit legislation in January for training programs, some of which may be good and some will be bad. I would hate to see this organization at some time awaken to the fact that we have let this whole thing slip away from us and get into the hands of those who have no business with that degree of involvement. Educational interests, such as IV Tech, have started to be interested and it may possibly evolve that various commercial ventures will begin to train these people, and, if so, I think we may find ourselves in very grave trouble. We have found that, as with many things, the Indiana School of Medicine has moved slowly, perhaps deliberately moving with a slow speed, which is advisable. I believe we should be a catalyst in every sense of the word as to such things as curriculum, length of training, type of certification or registration and whether these programs will be conducted at Ball State, ISU, University of Evansville or whatever.

I want to call your attention and recommend to you for reading an article which appeared recently in *Medical Economics*, a magazine which I seldom read myself. It was titled "A Government Insider Discusses Medical Fee Control." This is an interview with Robert J. Myers, who talked before the Oklahoma State Medical Association. You may remember he was chief actuary in the Department of Social Security from 1947 until his recent resignation. He is quoted as saying:

"I do not claim to have the answer as to whether physician remuneration is too high or too low, but I admit that the recent trend in physician fees is entirely justifiable in relationship to other prices and salary levels in general. One might think the term 'customary charge' is what the physician is currently charging his patients, just as though he had posted a sign in his office with his new fees. Instead, a peculiar interpretation has evolved holding in essence that the fee is not customary and the charge has been in effect about six months, after which the custom cannot change for another year. No such illogical limits prevail in other economical areas. The physicians of this country have been neatly trapped by the social planners who secretly envy their high income, whether real or only apparent, and so criticize them on any possible grounds."

DR. HILLIS: **I move that the Board of Trustees request the Commission on Medical Education and Licensure to immediately and forthwith become involved in the study of the programs to prepare medical personnel, including physician's assistants, and report back to this body.**

The motion was seconded by Dr. Smith, put to vote and carried.

DR. STEEN: I would suggest that, if the Board is willing, it devise some sort of a report to the House on this subject, calling this matter to the attention of the House, because it is extremely important.

CHAIRMAN: I have received the suggestion that we update Chapter XXXII, Sec. 1 of the Bylaws, which states that the House will operate on Robert's Rules of Order. There are two new Robert's apparently that are now becoming popular parlimentary procedures, and I would like the Board's permission to appoint a com-

mittee to study this and report to the Constitution and Bylaws Committee if there is a recommendation for change.

The motion was made by Dr. Cosman, seconded by several, put to vote and carried.

DR. SCAMAHORN: I am trying to get my commission appointments pretty well zeroed in and I thank those of you who have responded and I would like to talk to some four or five of you about finishing filling these vacancies from your respective districts. Any of you who have any particular wishes or interests of any of the members of your district who would be willing to work, I would appreciate having your recommendations, as I think the commissions are the backbone of our association. I am interested in finishing this job as soon as possible and therefore would appreciate receiving your recommendations as soon as possible.

DR. RAMSEY: The printing bill for the June issue was $7200, which was between two and three times as high as for the printing of ordinary issues. I want to tell you about a fine piece of news which was the result of a reader interest survey done by our State Medical Journal Advertising Bureau and its staff concerning all the 34 state Journals which belong to our advertising bureau. They took into consideration all the specialty magazines and drew up a reading tally of each state journal against 13 of the major nationally circulated journals—such as the Journal of the AMA, Medical Economics, M.D. News, Medical Aspects of Human Sexuality, Modern Medicine, Medical Tribune, Medical World News, and Patient Care—all magazines which are such a tremendous competitive program, against normal journals in the advertising market. There are three items in the findings: The state journal is at least third in that list of 14 in reader interest. In some cases it was second and in most states it ranked third. The second finding was that no more than one in seven practicing physicians expessed interest in the state journal. They were then asked to choose if they could only take three magazines out of this list of fourteen, which they would choose. The state journal was chosen more often than nine of the 14 total magazines. There are only two national journals that could say those things about themselves. The man that conducted this survey was a professor of Public Opinion Surveys at Emory University. He selected his audience by going into towns in ten of our states, each city being named either Columbus or Columbia. He missed only two physicians in all the towns that he went to and this complete survey gives us the kind of results we need to talk to advertisers and really demonstrates to them that physicians do read their state journals.

CHAIRMAN: We will now hear the report from the AMA delegation and I will call on Dr. Farquhar.

DR. FARQUHAR: The AMA convention was marked by four things of interest. The most widely publicized was that of designating criteria for therapeutic or elective abortions. The House of Delegates was unwilling to go with abortion on demand, as is now legal in the State of New York. The sense of the resolution was that this should be a medical procedure and designed for the best interest of the patient and should be performed by physicians only in the hospital and after due consultation.

The second item of interest was the Himler Report and I believe it was handled about the way we recommended with the Planning Committee of the House of Delegates formed and I would feel that the resolution which Indiana took to Chicago was the basic plan, although it was not the stated plan upon which the House of Delegates acted. I think this was our most successful action in the course of the convention.

Third, the disorders which were publicized so widely really did not amount to much, I did not think. I went to the special reference committee on the first day to watch all those who were there. I was not impressed by the Doctor Marxist type with hairy heads, hairy armpits and smelly bodies shouting slogans. While they did not impress me at all, I was impressed by some of the younger people who seemed to have very genuine concern for the health problems of the ghetto. I thought that there was a rather high quality person who was overlooked in the shuffle and scuffle and shouting of obscenities and all the rest of the things which color the headlines. From the special reference committee report, I think, came a re-emphasis of the more liberal point of view that organized medicine does care about what happens in the ghetto and what happens to minorities and that it should restate its willingness to listen and to act where it can.

Finally, Dr. Wesley Hall was named president-elect and I considered this a very beneficial experience.

DR. SHIELDS: I want to reiterate what Dr. Farquhar said and to state that Gene Sensenу did a good job as chairman of our delegation.

DR. STEEN: We have come back to the Board repeatedly and reported that we have had problems during the AMA sessions with internal struggles and internal strife and out of the eight AMA meetings I have gone to officially, this was one of the most pleasant. There was absolutely no internal strife and the delegation moved like a greased machine. I think the Board should know this, because the entire delegation is to be complimented for the very hard work they did and the excellent way everyone cooperated with everyone else.

DR. CLARK: I see that the AMA raised its dues $40.00. I would like to know whether the AMA is going to try to send out letters or any communication on this raise and what they plan to do with the money.

DR. NEUMANN: I think the understanding was that this information will be sent out by the AMA through the AMA News and other communication media explaining the need for the raise and giving you a more statistical financial appraisal of the situation.

DR. SCHUSTER: I move that the suggestion be carried out to have this information on the AMA dues increase sent to the members of the House of Delegates prior to the meeting of the House. The motion was seconded by Dr. Clark, put to vote and carried.

Matters Referred by the Executive Committee

DR. KERR: The Executive Committee would like to report to you for your information that the Indiana Chapter of the American Society of Internal Medicine has moved its office functions into the state association building. Next we have a letter from the Woman's Auxiliary to Dr. Steen which reads as follows:

Dear Dr. Steen:

The Executive Committee of the Woman's Auxiliary to the Indiana State Medical Association at its meeting on July 21st discussed the possibility of the ISMA billing for the dues for the Woman's Auxiliary.

By motion duly made and passed, the Executive Committee of the Auxiliary respectfully requests the Association to consider the following: A joint billing with the ISMA dues for the Auxiliary dues at the state and national level.

Under the present method by which the Auxiliary collets its own dues, the dues are not a deductible expense of our husbands. We believe if it could be worked out where the doctors could pay additional dues, that this might be found to be a method whereby the dues would be deductible. The Auxiliary could then be a separate budget item in the Association records.

Also another motion was adopted in which we would like to know if the medical association would welcome a change by the Auxiliary of its annual

meeting date from April so as to meet concurrently at the time of the annual convention of the ISMA. We believe such a change might be beneficial both to the medical association and the Auxiliary as far as attendance is concerned and would lighten the expenses of the Auxiliary.

If the men agree, we will present the possibility of this change to our House of Delegates for approval.

Sincerely,
Mrs. Irvin H. Sonne, Jr.
Recording Secretary

DR. STEEN: Mr. Chairmen and members of the Board, I believe it would be beneficial to have them meet jointly with the association at our annual convention as they have done in many other states. It has helped not only the Auxiliary attendance but helps the attendance at the state meeting. Now with regard to the joint system of billing as proposed here, I think this is a very highly charged issue. It is not something to be dismissed lightly, but I really do not think the Board should stick their necks out and make any form of a recommendation on this at all. I think the Board should prepare a report to the House indicating this request has been made by the Auxiliary but indicating nothing in the way of support or rejection but reporting it as fact and let the House of Delegates make the decision. I am sure there are some highly placed women who have highly placed husbands in the House who may be tremendously in favor of this, but I doubt the legality and believe the Board should check this out before even making a report. In any event, I believe the delegates should make their own decision. I can see the idea has merit from the standpoint of the Auxiliary both in terms of dollars and membership but I feel there are many physicians who will have great objection to this proposal.

DR. INGRAM: I understand from what Dr. Steen has said, and I would agree, that I don't think we should put ourselves in the position of supporting or even submitting a proposal to the House. It certainly sounds illegal to me. **I therefore move that this Board, as a matter of policy, do not allow joint billing of the Woman's Auxiliary with our state dues. The motion was seconded by Dr. Shields, and was discussed by Dr. Schuster and Dr. Thatcher.**

DR. HILLIS: **Until further study is done on this point, I move that the motion be tabled. The motion was seconded by Dr. Gosman, put to vote and carried.**

DR. GATTMAN: **I move that this matter be referred to legal counsel for opinion. The motion was seconded by Dr. Gosman, put to vote and carried.**

DR. GATTMAN: **I move that this Board invite the Auxiliary to conduct their annual convention concurrently with the annual convention of the Indiana State Medical Association. The motion was seconded by many, put to vote and carried.**

DR. KERR: I believe all members of the Board have received a copy of the SAMA MECO medical report. The Executive Committee has taken no action but refers this matter to the Board for its consideration.

DR. STEEN: We discussed this report at the meeting in Chicago where we had a full reproduction of their structure. We are now being asked by the Indiana Chapter of SAMA to endorse this program. It has come up as to whether the association should go on record as being for this project.

DR. GOSMAN: I think the idea is strong in principle. I have some reservations about its methods. The thing that came to my mind was the statement I made two years ago at the I.U. School of Medicine when we met with the Admissions Committee and I still feel very seriously about this. We are not going into a depth study about some of the admissions to the medical school. I would caution again that the Admissions Committee look more deeply into the individual's associations prior to his even getting into pre-medical school, relationships, etc. I would like to reserve an opinion on this until everybody has studied it very thoroughly.

DR. SCAMAHORN: I think you could say that the program is primarily a hospital-based preceptorship type of thing and does not go into a health center such as OEO or Community Health Center. The boy might go as a doctor if there were such a thing, but this is getting the doctor primarily more into the community non-teaching hospital as a preceptorship. I only add this to be somewhat favorable to it. My personal objection is that there are moneys to be paid to the student. When you see students, such as came to my home, there were 112 of them and they drove everything from Jaguars to Dune Buggies. There wasn't a car older than a 1964 in my driveway. I am not sure that these students need a stipend in order to do this community service. I question whether money has to be necessary in order to make this program grow and be successful. I am just beginning to wonder if this is always the answer in medical education.

The matter was further discussed by Dr. Clark and Dr. Thatcher.

DR. HARSHMAN: **I move that this matter be referred to the Commission on Medical Education and Licensure.** I am sure they will invite boys from our local chapter to present themselves for discussion of this matter.

The motion was seconded by Dr. Clark and Dr. Schuster, put to vote and carrried.

Dr. Kerr read a letter from the attorney of the Blue Shield Board and a resolution adopted by the National Association of Blue Shield Plans, together with the oath of office taken by the Blue Shield Board members.

DR. KERR: I believe I can say it was the consensus of the Executive Committee that the time has come to bid a fond farewell to Blue Shield.

DR. STEEN: We have spent more hours discussing our agreements and disagreements with Blue Shield than any other one subject. Blue Shield has been the subject of more resolutions in the House of Delegates than any other one subject. Historically, Blue Shield was a child as an organization of the ISMA. As a matter of fact, its first Board of Directors were counselors of this organization and it fulfilled the need at the time where certain types of funding might be achieved through private insurance. Blue Shield has grown so much that they act at times as though they no longer need us and are no longer responsive to what we want. I think the time has come that if we do not take some prohibitive action, we will find ourselves again, not only losing face, but we will find ourselves divorced from them by our own actions. **I therefore move that we introduce a resolution from the Board in the House of Delegates voicing our strong resentment to the change in attitude and action of the Blue Shield Board and that we hereby sever all relationships with them henceforth and forevermore. The motion was seconded by Dr. Ingram.**

The matter was further discussed by Dr. Neumann, Dr. Dukes, Dr. Steen, Dr. Petrich, Dr. Ingram, Dr. Kerr, Dr. Schuster, and Dr. Santare.

Dr. Dukes recommended that no positive action be taken and that the Liaison Committee of the Board meet with a like committee of Blue Shield.

DR. HILLIS: **Until further study, I move the motion be tabled. Seconded by Dr. Gosman and roll call vote was taken.**

Those in favor of tabling the motion were: Dr. Dukes, Dr. Kerr, Dr. Smith, Dr. Gosman, Dr. Schuster, Dr. Santare, Dr. Hillis, Dr. Clark, Dr. Gattman, Dr. Scamahorn and Dr. Hoyt.

Those opposed: Dr. Ingram, Dr. Petrich, Dr. Steen and Dr. Shields.

The chairman announced that the motion had carried by a vote of 11 to four.

Dr. Petrich then introduced Dr. William Sholty of Lafayette who will succeed Dr. Petrich as trustee from the 9th District this year.

DR. SMITH: I would also like to introduce my alternate trustee, Dr. Paul Inlow.

DR. KERR: We have not had the treasurer's report but there is a matter in it which I think we can take out of the report and act upon. It seems there will be a deficit of some $30,000 at the end of this fiscal year. We have discussed the transfer of some funds and I would like Dr. Hoyt to speak at this point.

DR. HOYT: We have reviewed the previous actions of the House of Delegates and this pertains to our student loan fund. You recall back about 1963 there was a good deal of government money available at a very low rate of interest and students began utilizing our loan fund much less. The House of Delegates at that time took action to reduce the amount. The action was to retain the $10.00 in the dues, that half of it go to AMERF, and make the other half available to the student loan program. The last sentence of the action of the House was "The allocation of such funds for this purpose shall be reviewed annually by the Executive Committee of the ISMA in conjunction with the Student Loan Committee." In 1966 we have an action of the Executive Committee which was then ratified by the Board. That action decided that the $40,000 which constitutes an irrevocable trust was enough to keep in the student loan fund. This $40,000 makes it possible to carry student loans up to the amount of $5,000. Now the number of loans since the guarantee program was started is 104, totalling only $91,000, so it is very obvious we do not need to keep more than the $40,000 in the guaranteed student loan fund. The action of the Executive Committee in 1966 ratified by this Board was the transfer of this excess that had already accumulated in the student loan fund over to the building fund. Now at the present time we have, according to the September 30, 1969, financial statement, approximately $75,000 liquid assets on the building which is aside from the assets of real estate. The Executive Committee last fall asked the auditors to set up an actual reserve fund in the building fund to be used as an asset against possible future expansion of the building and that sort of thing, so that is the plan of getting done but as we look at this financial statement which we are going to look at pretty soon, we see that there is $58,000 owed to the building fund by the general fund and now since the building fund does not particularly need more in liquid assets, I proposed to the Executive Committee last night that whatever deficit there is in the general fund as of September 30, 1970, after the audit, be retained in the general fund rather than be transferred over to the building fund. Perhaps I should say it the other way around, be permanently assigned to the general fund so it will no longer show as a liability to the general fund. **I would move that at this time whatever deficit there is to the general fund for the current fiscal year be made up from the money that is being held in the general fund for transfer to the building fund. The motion was seconded by Dr. Gattman.**

DR SHIELDS: Next year you are anticipating putting on the student program again and it ran around $30,000. My question is, are we going to be faced with the same thing next year? Is it logical to do it this way rather than escape the idea that in a year or two you are going to have to face an increase in the budget and in the dues? How many years can you transfer this?

DR. HOYT: Our committee has been wrestling with next year's budget and we do have something in writing that we can look at. We have not presented it to either the Executive Committe or this Board. It looks as though the thing pretty well hinges on whether or not we repeat the "Teen Health Happening". The largest part of our deficit is due to the Teen Health Happening. Now it is true that even without the Teen Health Happening we will be in the red a little bit this next year without a raise in dues. We may want to go ahead and raise them in October. If we do, then we still have the deficit from this current year that needs to be made up. I think we really have two separate questions. One, what do we do about the deficit of the current year; and, two, are we going to recommend to the House an increase in dues?

The motion was discussed by Dr. Schuster and Dr. Hoyt. **The motion was put to vote and carried.**

DR. STEEN: I would like to refresh the Board's memory. You remember last year we had delayed recommending to the House a dues increase for several years past the point where we really thought it was critical, due to rising cost of doing business, additional traffic, and additional programs. If you will remember, we predicated last year a figure of $50 per member would carry us for a matter of several years and would make up for the deficit we had permitted to accumulate by not increasing the dues in keeping with the cost of living index or consumer's index, or whatever it is called. At that time we decided to report annually based upon the way things looked, feeling that this was going to take about $10 a year for three to five years to get back to a point where the budget had leveled out and our net worth was subsequently added to it. As I remember it, the Fiscal and Economic Committee of the Board was to study the budget for the ensuing year and study our financial position for this year and recommend to the Board a figure to be asked for which would be widely publicized to the delegates prior to the meeting in October, so that the members would be fully informed of the needs of the association.

DR. HOYT: I think the net worth curve should be published along with that in the Journal so that our member has something he can look at and ask intelligent questions, if he really wants to question it.

CHAIRMAN: I would ask that Dr. Hoyt and Dr. Hillis get in contact with Dr. Wilhelmus during the noon hour so we may have a positive recommendation from the committee upon which the Board can act.

DR. KERR: The next item is relative to the settlement of the Blue Cross case and I have a letter from Judge Hamill which reads as follows:

June 29, 1970

Mr. James W. Waggener
Indiana Medical Foundation, Inc.
3935 N. Meridian St.
Indianapolis, Indiana

Dear Jim:

Re: Blanche Hickerson vs.
Mutual Hospital Insurance, Inc.

Enclosed herewith is a copy of the Agreement of the Parties and Stipulation and Entry Approving Agreement signed by the Court.

I am also enclosing my bill for $5,000 for services. I believe you will recall this was the agreed amount regardless of how much work I might have to do on the case including any possible appeal. Although we did not have an appeal, I actually had to resolve two lawsuits including the Wabash Hospital action to arrive at the judgment which we have.

I am pleased that we were able to resolve the substantive question in the manner in which we did. If for any reason Blue Cross does not change all the policies within six months time, please let me know, and we will see that the Court enforces its decree.

Sincerely yours,
Ralph Hamill

DR. KERR: We also have another letter concerning the loss Miss Hickerson took in a recent survey because of the fact that she was the plaintiff in the case against Blue Cross. The question was raised as to

whether the association has a financial obligation in this loss which did amount to $1,317.20. We refer this matter to you for your discussion.

DR. INGRAM: **If this was not in the original agreement, I frankly do not feel we are responsible and I will move that the ISMA not pay any portion of the bill. The motion was seconded by Dr. Santare, put to vote and carried.**

DR. KERR: I call your attention to the fact we have looked back through all the records and there is only one agreement that we would pay the attorney $5,000 for following this suit through the Circuit Court, if necessary. The agreement, made a long time ago, was that we would pay this flat figure regardless of the time and effort this suit entailed.

DR. KERR: We have a letter from Dr. Henry Nester, who is chairman of the Commission on Public Health, stating they have approved a new program for eradication of tuberculosis and asking our approval of the plan. In general, the present program for TB eradication in Indiana is to be the first priority, that all active cases be under drug therapy, isolated if an open case, and all close contacts be examined. A TB test should be had at least 90 days after the contact is broken. The second priority is that all inactive cases of less than five years be re-examined at least once each year. The third priority is the Child Center Program, that all new school enterers be tuberculine tested and all close associates of the positive reactor be examined as a possible source case. **The Executive Committee saw no objection and refers this to the Board with the recommendation that it be endorsed by this association.**

CHAIRMAN: **All in favor say "aye". The Board unanimously endorses these recommendations.**

DR. KERR: We have a letter from the Indiana Safety Council asking our continued support of their program by becoming members of this organization. It was recommended that organizations such as ours maintain a $250 to $500 annual membership. We ask the Board to advise us (1) If we should join this organization, and (2) What figure they would suggest we use in becoming members.

Following discussion, by consent, the chairman referred this matter to the Committee on Fiscal Matters of the Board.

DR. HOYT: For the treasurer's report, if you will turn to the first white page, I believe you will find this self-explanatory. The green page shows a record of our investment portfolio and I might comment that the Johnson funds which we purchased for $22 are now worth about $16.91. It has received an interest dividend of $86.38, which I figure out the annual rate would amount to approximately 1¼%, so we are not doing much better on the fund than we were on some of our other investments. However, in the course of our discussion, it was pointed out that many people still think this is a pretty good time to give consideration to further investment in equities. As you may remember, I was not very enthusiastic about getting into equities at the time you bought this, but I think now would be a pretty good time. **I move that this matter be referred to the Board Committee on Financial Affairs. Seconded by Dr. Kerr, put to vote and carried.**

Dr. Hoyt continued with his report, pointing out that the accumulative deficit of the general fund, as of June 30th, was $3,000. **On motion of Dr. Hoyt and seconded by Dr. Gattman, the treasurer's report was accepted.**

DR. INGRAM: I would like to have the pleasure of introducing at this time DR. R. D. Williams of Anderson, my new alternate from the 8th District.

CHAIRMAN: I will now call on Dr. Harshman to report on the Board's action on resolution 69-12.

DR. HARSHMAN reviewed the Board's resolution, which was prepared to be presented to the House of Delegates. **The resolution was discussed by Dr. Thatcher, Dr. Steen, Dr. Kerr, Dr. Neumann, Dr. Tyrrell, and motion was made and duly seconded that the report be accepted with some recommended editorial changes, put to vote and carried.**

The chairman then reviewed Board Report B concerning resolution 69-14 for presentation to the House of Delegates. **On motion of Dr. Santare, seconded by Dr. Harshman, put to vote, the report was approved.**

DR. STEEN: **I move to amend the motion, as I think the Board would strengthen its report by adding at the close "we urge that all members of the House continue to support the Indiana Plan and work towards its further implementation". The motion to amend was seconded by Dr. Shields and the main motion as amended was put to vote and carried.**

The chairman then reviewed Report C concerning resolution 69-16. Dr. Steen moved that the report be accepted with again including a specific recommendation "that the House go on record supporting the fact that ISMA should, through its Commission on Medical Education, set forth the requirements for an appropriate curriculum, recommend the period of training, recommend the pre-admission requirements for people admitted to the paramedical classes program and strongly urge every state university in Indiana to become involved, along with the local hospital in that area, in training allied health personnel." The motion to amend was seconded by Dr. Gosman, put to vote and carried. The main motion, as amended, was put to vote and carried.

Report F of the Board of Trustees was approved for presentation to the House on motion of Dr. Gattman, seconded by Dr. Kerr.

Acceptance of Report G was, on motion, made by Dr. Gattman, and seconded by Dr. Kerr. The report was further discussed by Drs. Gosman, Petrich and others.

CHAIRMAN: We have before us a report, as written by Dr. Gosman and his Joint Ad Hoc Committee on Education, which has now been amended six times editorially on six different occasions. Is there any further discussion germane to the verbiage of this Report G as changed? I would now entertain that discussion.

DR. KERR: **I would like to move that this matter be submitted to a short term ad hoc committee to come up with precise definitions of peer review. The motion was then made to table. The motion to table was put to vote and carried.**

CHAIRMAN: We have been mandated by the House to make a report to the 1970 meeting on this subject. I would hope that a revised report could be ready for our meeting in September, at which time a motion could be made to remove this action from the table so the report may be prepared for introduction before the House.

DR. KERR: **I again move that there be an ad hoc committee appointed by the chair to present to this meeting in September a precise definition of peer review and recommendations as to the formation of such a committee and submit such a report to the House at the October meeting. The motion was seconded by Dr. Hillis, discussed by Dr. Ingram, put to vote and carried.**

Report I of the Board Committee was discussed, amended editorially and then, on motion of Dr. Kerr seconded by Dr. Shields, the report, as amended, was approved for presentation to the House.

CHAIRMAN: I will now call on Dr. Dukes, chairman of the Liaison Board Committee on Blue Shield.

DR. DUKES: Resolution 69-27 was referred to my committee but I do not have

report written up as yet. The gist of the situation is that every company who buys Blue Cross-Blue Shield, Blue Cross goes in and the fellow who is buying says, "I have so much money." Blue Cross says, "Well it costs so much to keep them in the hospital and we pay so much and it costs so much," so what is left for Blue Shield to write up a policy they can sell for the amount of money left in the pot. If they have a lot of money, they get a good policy. If they don't have much money, they get less coverage. That is why there are so many different policies. If Blue Shield took the position we are only going to do this and that, there is a good possibility the prospective purchaser might say, "Well, we will go come place else with our business." If Blue Shield wants the business, they say, "We will write you a policy that will cover you for the amount of money you have to spend."

DR. STEEN: I think we are all aware of the fact that this is the way things work, but I think the Liaison committee with Blue Shield, when they write their report, would do well to have thought in depth as to what does constitute ideal health insurance. I would very much like to see them come forth with a series of recommendations as to what does constitute adequate insurance. I think it would be interesting to submit this to the House for discussion, to make official policy out of what we as a medical organization consider to be comprehensive and ideal health insurance plans. I think we would do not only the membership, but the citizens of Indiana a great service.

The motion was further discussed by Dr. Petrich, Dr. Kerr, Dr. Shields.

DR. DUKES: I will have a report for consideration of the Board at its meeting on September 12th.

DR. HOYT: Dr. Hillis and I were able to converse with Dr. Wilhelmus, who is ill, by phone on our noon hour and we are now ready to report on the three things referred to our committee. First: The Highway Safety Council membership—we feel that this does meet the criteria that the Board laid down in our last meeting and therefore recommend that we proceed to join this organization at a membership fee of $250. **The motion was seconded by Dr. Kerr, discussed by Dr. Farquhar, put to vote and carried.**

DR. HOYT: Second, the committee discussed the suggestion of investing some more money in some kind of common stock type of investment. While we are interested in this, at this time we do not feel it is quite right to do so but will continue to watch and report back at such time we have recommendation.

CHAIRMAN: Thank you, and we will accept this point as a matter of information.

DR. HOYT: The third item has to do with the budget which all of you have received. I call your attention to the anticipated deficit of $34,536. This figures out to $8.79 per member. This does include $25,000 for another Teen Health Happening. It does not include any contingency fund or any raises for the staff. As you can see then, $10 will cover this if there are no unforeseen problems. Our committee has agreed to recommend that the Board recommend to the House of Delegates that they approve a $10.00 increase in dues at this time, realizing again that we may go into the red a little bit. **I therefore move that this Board recommend that the House of Delegates increase the dues of the association $10.00, effective January 1, 1971, with all the information pertaining thereto. The motion was seconded by Dr. Kerr, discussed by Dr. Tyrrell, Dr. Clark, Dr Steen and Dr. Shields. The motion was then put to vote and carried.**

CHAIRMAN: I will now call on Dr. Ingram to report on the Board Committee on Emergency Medical Services.

DR. INGRAM: Dr. Farquhar tells me that Dr. Senseny and his Commission on Legislation will present the legislative package arrived at by the Commission on Emergency Medical Service before our General Assembly next year.

CHAIRMAN: Thank you, Dr. Ingram. I now recognize Dr. Farquhar.

DR. FARQUHAR: I appeared before you seven months ago, asked for and received your support for this legislative proposal. First, the basic standards recommended by the National Academy of Science for the operation of an ambulance service—we have the bill that not only incorporates this but also the essential equipment list identical to that of the American College of Surgeons. We ask that this list be adopted as the official list of the Indiana State Medical Association, as we feel the law should refer to the ISMA rather than the American College of Surgeons. Third, we asked for a "Good Samaritan" type of relief for the ambulance operator, driver or attendant; and lastly, we have asked the Board of Health for an ongoing series of training sessions for these people.

CHAIRMAN: We will now hear from Dr. Clark concerning the Orientation Program.

DR. CLARK: The orientation of new members is still being studied by the Special Activities Commission. I have informed the Commission that the Board of Trustees (due to the fact that the compulsory clause making it mandatory to attend one of two orientation meetings in their first two-year membership in ISMA was unworkable) would introduce a resolution at the fall meeting to the House of Delegates to abolish the Orientation Program.

The Commission felt that the Orientation Program should be continued being approached from a different angle leaving out the compulsory clause and making the Orientation Program available to all ISMA members. It was their and my opinion that all membership should be presented with facts about what ISMA and organized medicine is doing for them and how it is being done.

They have suggested that it be approached from two different angles—one at the student level at IUSM and second at the County Medical Society level.

1. Dr. Irwin was approached and he was very receptive and he suggested that a course with "credit" be offered to medical students labeled "Introduction to Medicine". It was felt the best way to present the program would be to put the program on one-inch video tape and that it be shown at Dr. Irwin's direction and also be made available to students through the school's statewide closed circuit television system which is now partly operational.

The idea was also approached to AMA through Mr. Tim Norbeck of the AMA Field staff. Mr. Richard DuMont, Director of the Radio, Television and Motion Picture Department of AMA began planning such a program, this program to be shown at the AMA June meeting. A copy of this program will be made available to all state and county medical societies.

2. The second idea, as presented by our field representative, Mr. Walters, was that an orientation program, using transparencies, an overhead projector and prepared script, be made available to all county medical societies meetings, our field representative putting the show on at county and district medical society meetings (similar to the Kentucky State Program). Dr. Robert P. Acher presented a companion program to the television presentation proposed for the IUSM and the group approach using overhead projection. His idea was that each new member be presented with a booklet with a looseleaf binder and a tape. This would make it possible for each physician to study the Orientation Program at his leisure.

The Commission finally approved the student approach and asked that I report to the Board of Trustees Mr. Walter's idea, for approval or disapproval.

This is the end of the formal report and, by way of discussion, may I add my own opinion that orientation is a real necessity and I believe that it should be solved by starting early with medical students followed up by county and district orientation.

It is my opinion that not 20% of our membership is really knowledgable about what the ISMA officers are trying to do to preserve physician-patient relationship; what they are doing to improve patient care; what they are doing to improve the knowledge of graduate physicians; what they are doing to preserve the rights of both patient and physician in the implementation of Medicaid and Medicare and, last but not least, what they are doing to preserve the dignity of our profession. It seems to me that we should continue the battle through county orientation with the aid of our ISMA field men and, if the county medical population is too small, then at the district level, all coordinated by ISMA.

DR. SHIELDS: Two questions: (1) If this course is put in at the University, is it anticipated it will be put in for credit and is it elective or mandatory? (2) Do I understand that you are recommending to the trustees that this orientation course not be mandatory?

DR. CLARK: That is right.

CHAIRMAN: **Dr. Kerr moves the acceptance of the report, and I think if you vote now you are voting in favor of this program as presented by Dr. Clark. However, I think his recommendation is that we discuss this, study it, and come up with the idea of whether or not this is a good valid, feasible program to adopt on an orientation basis throughout the state. The motion was then seconded by Dr. Santare, put to vote and carried.**

DR. STEEN: Will the Board make any recommendation to the House about orientation at this time?

CHAIRMAN: Yes, to disclaim the Orientation Program by requesting the Commission on Constitution and Bylaws to prepare the appropriate change to the Constitution and Bylaws to bring them back to the arrangement we had prior to the mandatory orientation program.

CHAIRMAN: The next trustee Report K constitutes a white paper from the Board of Trustees concerning convention sites and facility requirements. **I ask your permission for submission of this to the House of Delegates. The motion was made by Dr. Kerr, seconded by many, put to vote and carried.**

The president then discussed some of the problems of the meeting in South Bend and asked that a special committee be appointed composed of himself, the president elect, the chairman of the Board, and the chairman of the Executive Committee, to work with the local arrangements committee concerning some of the problems. On motion duly made and seconded, approval of the organization of such a committee was granted.

CHAIRMAN: At the last meeting we had a matter referred by the Executive Committee to the Board which was not acted upon at that time. The Executive Commitee at that time moved to recommend to the Board that a resolution be prepared from the Board having the effect of withdrawing the ISMA support from the Regional Medical Program, tacitly and completely with no reservations. The motion was carried by the Executive Committee and now becomes a matter for discussion by this Board.

DR. STEEN: **I move the Board adopt such a resolution. Seconded by Dr. Kerr.**

DR. STEEN: I would like to discuss this matter. Sitting on the Regional Advisory Group, not as a representative of this organization, but as a representative of the Association of Medical Clinics, I am distressed, as are so many other physician members of the Regional Advisory Group, about the service organization that has taken place. This is like so many other governmental programs. They start out as an educational function and soon they are supporting in toto service functions. One was just passed last week at the Regional Advisory Group meeting for providing technical services of radiation physicists to all the hospital radiologists in Indiana who are using cobalt machines, because they have learned through a certain study in the College of Radiology that they are not properly calibrated and they do not know how to calibrate and all this stuff so now by sending in a plot plan of the patient and where his tumor is, etc., they are going to, through Regional Medical Program funds and the use of radiation physicists, calculate exactly the dose and the technique and all this other stuff a radiologist already knows. In my judgment, a radiologist who is practicing therapeutic radiology has the same responsibility to maintain his equipment and obtain what consultation he needs, just as Dr. Hoyt and Jim Harshman do to maintain their SMA-1260's in proper working order, and it is my responsibility and all the rest of us who own electrocardiography equipment to keep it in working order and have them properly standardized and I do not see that this is any business of the Regional Medical Program to get into a service deal such as this. At the last Board meeting we agreed to defer action on this matter until such time as Dr. Stonehill appeared before the Board the following day. The suggested questions that were proposed to be asked did not materialize and I kept still because I was tired of pillaring him. He has spread the word around that he and I had a great vendetta going and that I am out to get him. Nonetheless, I think the organization is bad and I think this is the basis on which we want to withdraw our support.

The matter was further discussed by Dr. Gosman, Dr. Kerr and Dr. Shields.

CHAIRMAN: **All in favor of the motion of Dr. Steen to withdraw ISMA support from the Regional Medical Program, and the second by Dr. Kerr, please say "aye." The motion was carried.**

CHAIRMAN: We will now hear reports from trustees.

DR. HILLIS: I would like to report that comprehensive health planning in Miami County is almost a reality without the support of the County Medical Society. I am informed that the director is the administrator of the local hospital who has everything going except the doctors. No one will serve on the committee, except one doctor has agreed that he might serve on comprehensive health planning. As you well know, they have no use for government programs in that county.

CHAIRMAN: You remember Dr. Merritt Alcorn appeared before the Board meeting and discussed the attitude of the Board of Medical Registration concerning a Senator's proposed bill to be presented to the legislative session concerning licensing of foreign physicians. I believe the Board should take some action on a formal policy statement and refer this to the Board of Medical Registration and Licensure.

DR. GOSMAN: **I move that we support Dr. Alcorn's comments. The motion was seconded by Dr. Shields, put to vote and carried.**

CHAIRMAN: We had planned to have a presentation on Medical Foundations by Dr. Corcoran, who attended the meeting in California, and by Dr. Steen, who is on the AMA Committee. Dr. Corcoran was unable to be with us, so I will ask Dr. Steen to make the report.

DR. STEEN: First of all, I should like to issue a general disclaimer. I am not attempting to sell you anything. We envisioned this at the last Board meeting as a piece of information for your edification. Those of you who don't need edifying, feel free to go to sleep. Actually, the foundation concept had its inception with the so-called Kaiser Plans which, in turn, were the product of the depression. When they built the Grand Coulee Dam, there were some 10,000 workers employed near an area where there was no medical service and Dr. Sydney Garfield was asked to attempt to provide care for those individuals close to him on the site. Apparently the economics of the private practice of medicine of Dr. Garfield at that time were

not overly good and stated repeatedly by him, so he decided he could perhaps eke out a more satisfactory living by attempting to provide some forms of care for the people who were working on the Grand Coulee Dam. Therefore he undertook to care for these individuals on a percapitation basis, which at that time was $1.00 for an individual per month, $12 a year, for which he agreed to provide total care. This worked out quite well and when the second World War started and the ship building empire of Henry Kaiser expanded into Portland and Oakland, California, and other West Coast ports, there was a influx of a tremendous number of people into the area who did need medical care. There had been a number of physicians drafted from the area so that there was a tremendous shortage of medical manpower. Garfield was again approached by Henry Kaiser to set up an appropriate type of medical facility to take care of these individuals, which he did. Henry Kaiser spent a considerable sum of money to provide some facilities.

Through development of these facilities, we finally got down to the post-war period in which there was no longer the necessity that existed previously, but the facilities were there, and the Kaiser Foundation continued to extend its services to other individuals. At that particular time or a little later there were some revolutionary changes in their delivery system, in that the Kaiser Plans (the actual doctors who provided the care) were no longer employees of the Foundation but became individual partners, leasing their space and hospital facilities from the Kaiser Foundation. It is interesting to note that virtually all of the facilities were built with private funds, with bank loans, were not subsidized by the government. They are voluntary plans and they still render a rather significant service.

By making some very interesting calculations on the reports given to the Association's Medical Clinic, it is apparent that most of these physicians working the Kaiser Plan get a gross income of about $25,000 before taxes, but one must bear in mind that is for a 36-hour week, because only on alternate week-ends do they provide service, either in the clinic or in the hospital. They are all given a half day a week to pursue postgraduate education, which they need not necessarily do. They must take the postgraduate education if they want the day off, but they may elect to work and make additional money. So the $25,000 may not necessarily mean that income, and it works much like any other partnership does. They have, through utilization and through the extensive use of preventive techniques, through the use of the out-patient service, managed to have a very low incidence of the utilization of hospital beds and on the average they run a utilization of 2.3 days less than the general hospitals can provide, without supposedly sacrificing care.

Garfield has recently come into some prominence, in that *Scientific American* (and I urge you all to get this article and read it), recently published an article on Garfield and on the prepaid medical care in which they quote Garfield as saying that he doesn't think that national health insurance is the solution to the medical care delivery problem in the United States. They have found, by making care available, more and more individuals utilize the care and further increase the shortage rather than solve the shortage. It is his opinon that the financing technique is not the problem.

The problem is the provision of care and we have said this before, and I personally believe that implicitly; and I believe that we have to experiment with new techniques in the delivery of care separate from the traditional systems which we all know and are either addicted to or adhere to, whichever it may be. I think, for this reason, we must be involved in the physician's assistant program which I discussed with you this morning. I think we have to get into various types of health screening, various types of multi-phasic screening, and we have to reserve our efforts for those things we are best trained to do. Most changes in the delivery of health care are the result of economic or social pressures and not the inherent desire on the part of the physician to change. Oftentimes physicians do band together to furnish service, but here again it is an economic pressure or a social pressure that causes this banding together. The formation of voluntary groups, when you get basically down to the nuts and bolts of these organizations such as the one of which I am a member, are formed for economic and social advantage to the individuals involved in the group. They are not altruistic organizations. We are as interested in collecting our dough as you are in collecting yours. And, to us, it is of major importance, since we are feeding 92 allied personnel mouths a month before we get one. So bear that in mind when you think about any change in the traditional system of the delivery of care.

In California in the late 30's they were faced with this problem, in that the labor unions were ready to build a sizeable health facility which in effect threatened the economics of the practicing physicians in the area. A few years back, to bring it closer home, the physicians of Lake County, Indiana, were faced with this threat. United Steel Workers threatened to spend $33 million building a facility. Many of us laughed facetiously and said, "How are you going to staff it?" And then we sat down and thought about it a little bit and thought, well, we have a certain number in our societies who will sell out to the enemy. They can import foreign trained physicians. They can obtain physicians who aren't doing too well on their own. Maybe they can staff it.

So we said, "What can we do?" We looked to California for its solution.

The California solution was the foundation concept. The foundation concept is nothing more than a county medical society forming a separate corporation for the provision of medical service. It is run completely by the county medical society. The county medical society and the physicians who are members of the foundation elect the officers and set forth the rules. The county medical society derives benefit from this, in that they can use some of the personnel used in the foundation to perform their functions and thereby help to ease their dues structure to a reasonable level. At any rate, once the legal structure is set up for providing medical care, those individuals charged with the responsibility of running the program devise a series of programs that they want to sell to the community. They go to the physicians in the community and say, "Do you wish to participate or do you not. If you wish to participate, the following advantages accrue to you: Number one, within about five days after you submit your bill for services rendered, you will get a check, so you can be assured of 100% collectability of what you bill the Foundation for. But, in return for this economic advantage, you must agree to be bound by the schedule that we have devised as the usual and customary schedule for this particular area."

These plans have had phenomenal success in California. There are now in excess of 100 such foundations in operation in California, Oregon, Washington. They have expanded to involve areas in Colorado and recently in Ohio. There are two foundations that I know of set up in Indiana: Vanderburgh County and Lake County. Vanderburgh is showing some signs of regeneration. Lake, there has been some discussion about it, but it has not been reactivated as such. Technically, physicians decide what should be paid for a given service, taking into account all the facts we must each consider in our individual doings day in and day out. They have set forth some very definite criteria to guide the claims clerks who process the claims very quickly. If there is any question about

the claim, appropriate correspondence is carried out and it is up to a physician to review it, and make the decision. If he has any question after the physician has made the decision, it goes to the Board of Directors or their Review Committee to make a determination, and their determination is final.

They have been able to achieve a number of very beneficial things insofar as the economics of medicine are concerned because they have been able to amass a tremendous amount of data about utilization patterns. They have been able to set forth very definite criteria for treating virtually every entity. I will say that I reviewed San Joaquin Valley's criteria for the treatment of acute colli cystitus, duodenal ulcer with bleeding, acute myocardial infarction. And I will say that the criteria are very liberal, that if I were treating a case under the criteria set forth by San Joaquin Valley Foundation, I would experience no difficulty whatsoever, because they are infinitely more liberal in what they consider to be reasonable in caring for that case than I usually do.

To cite one example, they allow three electrocardiograms a month for up to six months. Now I will grant you that occasionally there is a patient who may need more than that. But the average coronary, I don't think you need three electrocardiograms a month for up to six months after the coronary. They allow enzymes studies up to the seventh day after admission on a repetitive basis. Anybody who knows anything about the enzymes know that, by the third or fourth day, you might as well quit doing them if they have risen and gone down, because they are going to go up again if there is another episode.

The situation has grown continuously and it is attracting the attention of state and county medical societies all over the country. Government intervention may slow the process to a certain point but, on the other hand, it is entirely possible that if the foundation concept were implemented more widely and relatively quickly, this might solve a portion of the problem that the social climbers are intent on forcing upon us. There again you get into a matter of philosophy, because I am not so certain (as a matter of fact I am certain in the opposite direction) that the social climbers want this for a vastly different reason than what they put out to the public and what they tell us. They want this as a scheme to ultimately socialize the entire country. The health care of the poor is only a backdrop which they are using for their own purposes. We could find a way, and if the foundation concept is, in any measure, a way in which we can fulfill this need, we may be doing ourselves a very great service.

This is briefly some background material. I will be happy to answer more detailed questions. I have rushed through this very greatly. I have left out a great deal of information. Dr. Corcoran was authorized to attend a conference held by the 100 foundations of California and the Northwest a month or so ago, and he was to be here to report on this in more depth, since they have some very exciting things in the offing that they intend to do and hope to get into in the very near future.

I think we also have to recognize and take a long look at the fact that the West Coast has always been more visionary—you can call it more liberal than we have been in the Midwest. Many of the valid innovations that have occurred in medicine have come as a result of their experimentation; however, I think they are further down the line than we will be in ten years if we are still serving in the state in which we know it today ten years from now. But I think this is something we all ought to be knowledgeable about. It is something we all ought to give some thought to and, as I said in my beginning remarks, I am not trying to tell you all that we ought to have one large, huge foundation in Indiana or that every community in Indiana is adaptable to a foundation-type setup today or next week, or even ten years from now. But I think you should know something about it. You can't refute some of the things. I think it is helpful to be able to talk intelligently to people and I think this is particularly important, in view of the fact that I am absolutely certain and I know this for a fact, there will be several resolutions introduced to the House this fall asking that the State Medical Association attempt to develop a foundation-type approach in solving the Medicaid problems. To give you the benefit of my thinking about that is the corollary to what we have been talking about. I don't ever think this would work on a statewide basis. I think if such were to happen, we might be able to have some sort of super foundation run or sponsored by State Medical, but I think almost certainly every community would have to have their own branch off the mast foundation or a separate foundation to deal with the specific problems in each individual area. I don't think you can monolithically set forth a system for the 4,000 physicians in Indiana any more than you can set it forth to some 30,000 physicians in California. They have found that it has been even impossible there. This is why there are on hundred separate foundation plans.

CHAIRMAN: Thank you, Dr. Steen. Is there any action the Board would like to take? The report was discussed by Dr. Gosman, Dr. Shields and Dr. Santare.

CHAIRMAN: I have asked Dr. Tom Middleton, chairman of the Commission on Public Information, to appear before us as he desires to present a matter of business to this Board.

DR. MIDDLETON: Several years ago this association decided to join in what is known as a Community Service Award given by the A. H. Robins Co., and the association developed certain criteria for physicians to receive this award. We had three nominations made for this award. After a review of all the good things said about these physicians, the Commission voted to recommend to the Board that they approve the selection of Dr. Daniel Cannon of New Albany as the recipient of this award.

DR. KERR: I would like the privilege of making the motion that this Board accept the recommendation of the Commission that Dr. Cannon be selected as the recipient of this award. The motion was seconded by Dr. Gosman, put to vote and carried.

CHAIRMAN: I will now move to the nomination of two members for the Editorial Board for a three year term ending December 31, 1973. The election of these people will take place October 8th. In addition, Dr. Hickman, whose term on the Board does not expire until December 31, 1972, is leaving Indiana and will take up residency in Florida, effective December 1, 1970.

DR. KERR: I would like to nominate Dr. Charles Ellis of Bloomington, a pathologist.

DR. SHIELDS: I would like to suggest Dr. Heaton, a pathologist, and I will report back to you at the next meeting concerning him.

CHAIRMAN: Will you both talk to these men and be prepared to give us a report at the September meeting?

The chairman then reviewed actions of the Board of Trustees which he proposed to present to the House of Delegates. The presentation of the report was approved by consent.

CHAIRMAN: I call your attention to the fact that the next Board meeting (on September 12-13) will be held at the Imperial House Motel in Terre Haute and please send in your reservation cards promptly.

There being no further business, the meeting went into executive session.

EXECUTIVE SESSION

CHAIRMAN: Is there any business to come before the executive session of the Board?

DR. SHIELDS: I would like to ask one

question concerning the financial participation of the ISMA in the computer program in which the association put $5,000. My question—is this a one time gift or is it going to be done each year? If one time is this association to get any stock in this operation?

CHAIRMAN: One time only and it was just an outright gift. The money was used, as has been explained, as such for an investigative analysis of the capabilities of the computerized program and an analysis being made by a group from Indiana University.

DR. GOSMAN: This may be completely out of order because the peer review matter is tabled but I think our esteemed president in his address so beautifully laid out the concept of the review committee and I think right now I would like to suggest that we say "Review Committee" and you go back to what he said at that time. I think he laid it right out so we could use all this material in any argument that might come up when this is presented to the House of Delegates.

CHAIRMAN: I think in the next meeting we certainly will have additional conversation about this following the results of the committee's activities between now and then. I think you are perfectly right. The House of Delegates would support the president's remarks. There was no issue taken on some of the remarks he made and it was passed in toto in the Reference Committee. The House then passed it and I think this amounts to an agreement which is a necessary part of our function.

Dr. Steen then discussed a letter he had received from a doctor in Maine concerning Peer Review.

There being no further business, the Board adjourned to meet again at the Imperial House in Terre Haute at 6:00 p.m. Saturday, September 12th.

EXECUTIVE COMMITTEE

September 12, 1970

The Executive Committee of the Indiana State Medical Association met at the Imperial Motel in Terre Haute. The meeting was called order by Donald M. Kerr, chairman, at 1:00 p.m.

Roll call showed the following present: Donald M. Kerr, M.D.; Burton E. Kintner, M.D.; Lowell H. Steen, M.D.; Malcolm O. Scamahorn, M.D.; Peter R. Petrich, M.D.; Lester H. Hoyt, M.D.; Hugh K. Thatcher, Jr., M.D.; and James A. Waggener.

MINUTES OF THE JULY 25th MEETING—The minutes of the meeting held July 25 were approved on motion of Drs. Petrich and Kintner.

MEMBERSHIP REPORT as of August 31 was approved by consent.

Number of members as of December 31, 1969	4,482
1970 members as of August 31, 1970:	
Full dues paying members	3,935
Residents and interns	84
Board remitted	56
Senior	352
Honorary	3
Military	39
Total 1970 members as of August 31, 1970	4,469
Total 1969 members as of August 31, 1969	4,455
Number of AMA members as of December 31, 1969	4,330
1970 AMA members as of August 31, 1970	4,303
Full dues paying	3,769
Exempt, but active	534
	4,303
Number who have paid state dues but not AMA dues as of August 31, 1970	166
Number who paid state dues but not AMA dues as of December 31, 1969	152

Headquarters Office

PROPOSED CHANGES IN OFFICE LAYOUT—The secretary presented a proposal for enlarging desk space in the Headquarters office and a quotation from the Dodd Electric Service for changing electrical service. The changes were approved on motion of Drs. Petrich and Kintner.

JUNIOR ACHIEVEMENT FAIR—An offer for the association to maintain an exhibit during the Central Indiana Achievement Fair was turned down on motion of Drs. Steen and Petrich.

INVESTIGATION OF M.D. SYSTEMS—The secretary asked permission to further investigate M.D. Systems, which is a firm operating in California and is a subsidiary of Mead Johnson Company for handling insurance claims for physicians. The investigation was approved on motion of Drs. Petrich and Kintner.

Treasurer's Office

THE TREASURER GAVE A REPORT on the income and expense statements of July and August; the cash and securities report and investment portfolio. The report was approved on motion of Drs. Hoyt and Petrich.

Organization Matters

CONTRIBUTION MEDICAL ASSISTANTS PUBLICATION—A contribution to the American Association of Medical Assistants publication of $25 was approved on motion of Drs. Petrich and Steen.

NEWS CLIP ON SENATOR HARTKE—A news clip reporting Senator Hartke had advised the chiropractors to apply pressure to the Senate Finance Committee for inclusion of chiropractic services under Medicare was reviewed for the information of the committee.

CORRESPONDENCE DR. GENE S. PIERCE—The secretary reviewed correspondence with Dr. Gene S. Pierce and his request for information on nurses dispensing medication. On motion of Drs. Petrich and Steen, Dr. Pierce is to be advised that if the doctor is making an examination and prescribing the medication, the nurse has a perfect right to distribute the pill on the doctor's order.

REQUEST FOR USE OF MAILING LIST BY DR. J. P. DONOHUE—A request of Dr. John P. Donohue for use of the mailing list was approved on motion of Drs. Steen and Petrich.

RESOLUTIONS ADOPTED BY LPN GROUP—A review of the resolutions adopted by Licensed Practical Nurses Association was given for the information of the committee.

PUBLIC HEALTH MATTER—A letter from the Public Health Officers of St. Joseph County concerning the establishment of a Drug Abuse Clinic and staffing of same was reviewed and, on motion of Drs. Steen and Hoyt, this matter was referred to the Board of Trustees and to the Section on Nervous and Mental Diseases with the recommendation that they establish guidelines for operation of this type of clinic.

MONEY MANAGEMENT—A letter from Money Management for Professionals seeking the approval of the asociation for conducting seminars was turned down by consent.

BLUE SHIELD: MICHIGAN-CALIFORNIA—Matters relating to the Blue Shield problem in Michigan and California were reviewed for the information of the committee.

RECOMMENDATIONS TASK FORCE ON MEDICAID—Recommendations of the Task Force on Medicaid and Related Programs as of June 1970 stating that chiropractic should not be included as a provision under Medicare and Medicaid was read for the information of the committee and it was suggested that copies of this be sent to Indiana Congressmen and Senators.

LETTER FROM AMA REGARDING AMA-ERF MONEY RAISING CAMPAIGN—A letter from the AMA offering to put on a drive to obtain funds for AMA-ERF was turned down by consent.

CORRESPONDENCE AMA AND DR. WALTER—Correspondence between an Indiana physician and the AMA referring to the AMA abortion policy was reviewed for the information of the committee.

GOSHEN PHYSICIANS MATTER—A petition signed by a group of physicians in Indiana and forwarded to the AMA expressing disagreement with the AMA abortion policy and the AMA's reply was reviewed and the secretary was instructed to write to these physicians pointing out that the AMA action was not to provide abortion service on demand and regardless of what the AMA's position is, Indiana physicians are governed by Indiana law.

IVY TECH MATTERS—Several matters dealing with IVY Tech and commitments for service training programs were reviewed and, on motion of Drs. Petrich and Steen, this is to be referred to the Commission on Medical Education and Licensure.

HEALTH INSURANCE ASSISTANCE ACT—The Health Insurance Act of 1970, known as H.R. 18567, was reviewed for the information of the committee.

A REPORT BY BLUE CROSS AND BLUE SHIELD TO WELFARE ADVISORY COMMITTEE FOR MEDICAL ASSISTANCE—A report from Blue Cross and Blue Shield to the Welfare Advisory Committee for Medical Assistance on welfare programs was reviewed for the information of the committee and is to be reported to the Board of Trustees.

PROPOSAL DATA-AIDS—A proposal from DATAaide/Associates for taking over the billing for the association on membership dues was reviewed and, inasmuch as a representative was to appear before the Board the following day, the matter was taken as information.

DATES OF PRE-LEGISLATIVE STUDY CONFERENCES—A letter from the Indiana Public Health Association announcing the dates and places for regional meetings for pre-legislative study conferences was reviewed for the information of the committee.

PROPOSED MEDICAL DISCIPLINARY ACT—A proposed Medical Disciplinary Act was presented and, on motion of Dr. Petrich, this was deferred pending a meeting with the Board Committee later in the day.

OCHAMPUS CONTRACT AMENDMENTS—On motion of Drs. Petrich and Kintner, the president was authorized to sign the amendments to the OCHAMPUS contract.

REPORT ON SURVEY PROFESSIONAL LIABILITY—A report from the Continental Casualty Company concerning the recent survey on Malpractice Insurance was reviewed for the information of the committee.

Convention Matters

REQUEST OF COMMISSION ON CONVENTION ARRANGEMENTS—A request of the local committee on convention arrangements for an appropriation of $100 for the golf trophies and $50 for the skeet prizes was approved on motion of Drs. Scamahorn and Petrich.

POLICY ON HONORARIUMS FOR SECTION SPEAKERS—The question concerning payment of honorariums for section speakers was discussed and whether the honorarium is to be made payable to the Section or to the speaker and, on motion of Drs. Petrich and Hoyt, the honorarium is to be paid directly to the speaker.

PROGRAM 1970 MEETING—The program for the 1970 meeting was reviewed and the executive secretary stated that the Gaslight people had recommended the addition of two musicians and one extra girl at a cost of $325. The addition was approved by consent.

FUTURE CONVENTIONS—The secretary reported on the availability of the convention center in Indianapolis beginning in 1972 and reviewed the cost of having the meeting in such a place and this matter was referred to the Board of Trustees.

Future Meetings

AMA MEDICAL RESEARCH-AIR POLLUTION CONFERENCE in New Orleans October 5-7, on motion of Drs. Steen and Kintner, no representative is to be sent.

INDIANA CHAMBER OF COMMERCE meeting in French Lick on October 22-23, and their annual meeting on November 17; it was assumed Dr. Wood, our representative on the Board of Directors, would attend these meetings.

CONGRESS OF COUNTY MEDICAL SOCIETIES meeting in Cincinnati November 6, 7, 8, on motion of Drs. Steen and Kintner, the president and president-elect were authorized to attend these meetings if they so desire.

AMA MEETING ON QUACKERY to be held in Boston on November 29th was called to the attention of the committee.

CLINICAL MEETING AMA—the program for the Clinical Meeting in Boston, to be held November 29-December 2, was reviewed and, on motion of Drs. Petrich and Scamahorn, the association will operate a hospitality room on Sunday, Monday and Tuesday from 5:00-7:00 p.m. By consent, it was agreed that a breakfast would be held for the delegation on Monday, Tuesday and Wednesday mornings and that the room would be available at noon each day for the official family.

There being no further business, the meeting was adjourned to meet again at Randall's Inn, South Bend, on Monday, October 12, 1970, at 12:00 Noon.

The above minutes were approved in each separate part and as a whole on October 12, 1970.

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IMMEDIATE OPENING: Internist or general practitioner to join six man multi-specialty group in northeastern Wisconsin. Excellent professional opportunity to practice in a friendly community, only two actively practicing physicians (general practitioners) in the community outside of our clinic. Salary commensurate with training and experience first year and then full partnership. Ideal, safe small city living for the family on scenic Lake Michigan with excellent fishing, boating and hunting. All this and still only 1½ hours drive to Milwaukee or 45 minutes to Green Bay or lovely Door County. For complete details contact Robert E. Myers, M.D., Garfield at 23rd, Two Rivers, Wisconsin 54241.

GRADUATE PHYSICIAN ASSISTANT wishes employment after December with a general practitioner who is overworked in his practice. Salary is negotiable. All inquiries should be sent to Danny P. Fox, Clinical Corpsman, Cleveland Clinic Haspital, Cleveland, Ohio 44130.

SEMI-RETIRE IN FLORIDA!! Clean air, fishing and beaches. Emergency room physicians needed full time for expanding Florida hospital. Must have Florida license and qualify for active staff privileges. Fee far service with guarantee of $219.00 per 24-hour day. Na overhead. Hospital does billing of fees at no expense to you. Write E. Gilbert Slatton, Administrator, Wuesthoff Memorial Hospital, Rockledge, Flarida 32955.

WANTED: General practitioner to join active group in large non-OB, non-pediatric practice with large industrial component. Well-established. New building. X-ray—laboratory facilities—Cincinnati area. Future bonanza for right person willing to work. Write Box 361, The Journal, 3935 N. Meridian St., Indianapolis 46208.

CHIEF OF MEDICAL STAFF: Regular hours, $30,589 annually, excellent fringe benefits. Smog free, peaceful, cultural, vacationland community. Sound Great? It's all yours if you are a boarded internist or generalist. Apply to M. Duane Sommerness, M.D., Box C, Room 276, Traverse City State Haspital, Traverse City, Michigan 48964. An equal opportunity employer.

MONTEGO BAY JAMAICA: Three bedroom, three bath villa; three servants; swimming pool; private beach; competitive rent. Nearby golf, fishing, etc. 10% off national advertised rent for ISMA members. Inquire for details: D. F. Buehner, M.D., 3700 Bellemeade, Evansville, Ind. 47715.

WANTED: G.P. to associate with 34-year-old G.P. in West Central Indiana. Brand new clinic facilities; financial remuneration excellent. Write to J. Franklin Swaim, M.D., P.O. Box 185, Rockville, Indiana 47872. Telephone: 812-569-3182.

TO GENERAL PRACTITIONERS AND INTERNISTS: Winter is Coming! Move to sunny Arizona! Join a general practice group in a community of 70,000. Excellent living conditions and hospitals, corporation advantages, and a lucrative association. Contact Physicians and Surgeons, Ltd., 550 North Country Club Drive, Mesa, Ariz. 85201. Phone: 602-969-3511.

G. P. OPENING: Leaving for residency. Attractive lakes area Northern Indiana; take over well established practice, or association arranged; share calls with five other GPs. Clifford Fiscus, M.D., 827 S. Union, Warsaw, Ind. Telephone (219) 267-8176 ar 267-6192.

EASTERN ILLINOIS Progressive community 42,000 population; Universities of Illinois, Indiana and Purdue nearby; good schools, including junior college adjacent to hospital; new, well equipped General Medical and Surgical Hospital; interested in all specialities as well as GP; away fram busy metropolitan traffic; 120 miles south of Chicago, 85 miles west of Indianapolis via I-74; beautiful 9-hole championship golf course on grounds; an equal opportunity employer; salary $19,643 through $29,752, based on training and experience. Licensure in one state required for appointment. Write or call chief of Staff, Veterans Administration Hospital, Danville, Illinois 61832. Telephone: Area Code 217, 442-8000, extension 353.

BOARD CERTIFIED PSYCHIATRIST. Average daily census — 1204; predominately psychiatric VA Hospital, located in East Central Indiana. Special programs in psychiatric and geriatric rehabilitation; alcoholic treatment unit. Active medical service. Family rental units at reasonable rates usually available on hospital grounds. 30 days leave annually; retirement; health, life insurance plans without physical examinatian; and other benefits. Will pay moving expenses. Salary $19,643 — $29,752 depending on qualifications. License any State required. Equal opportunity employer. Contact Chief of Staff, VA Hospital, Marion, Indiana, 46952, or call Area 317, 674-3321.

WANTED—LOCUM TENENS: Middle of December ta the middle af January—general practice of medicine. Contact Stephen D. Smith, M.D., Knightstown, 345-5495 or 345-5335.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: $3.00
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November, 1970 Indianapolis, Indiana

The Journal of the Medical Association

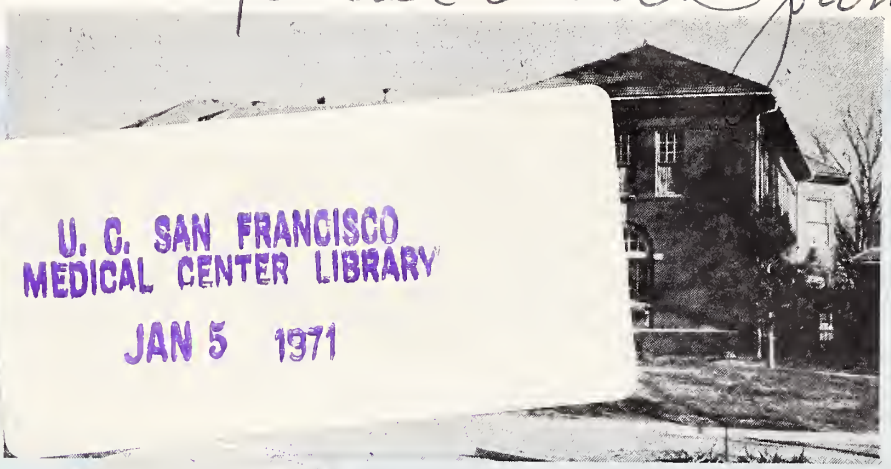
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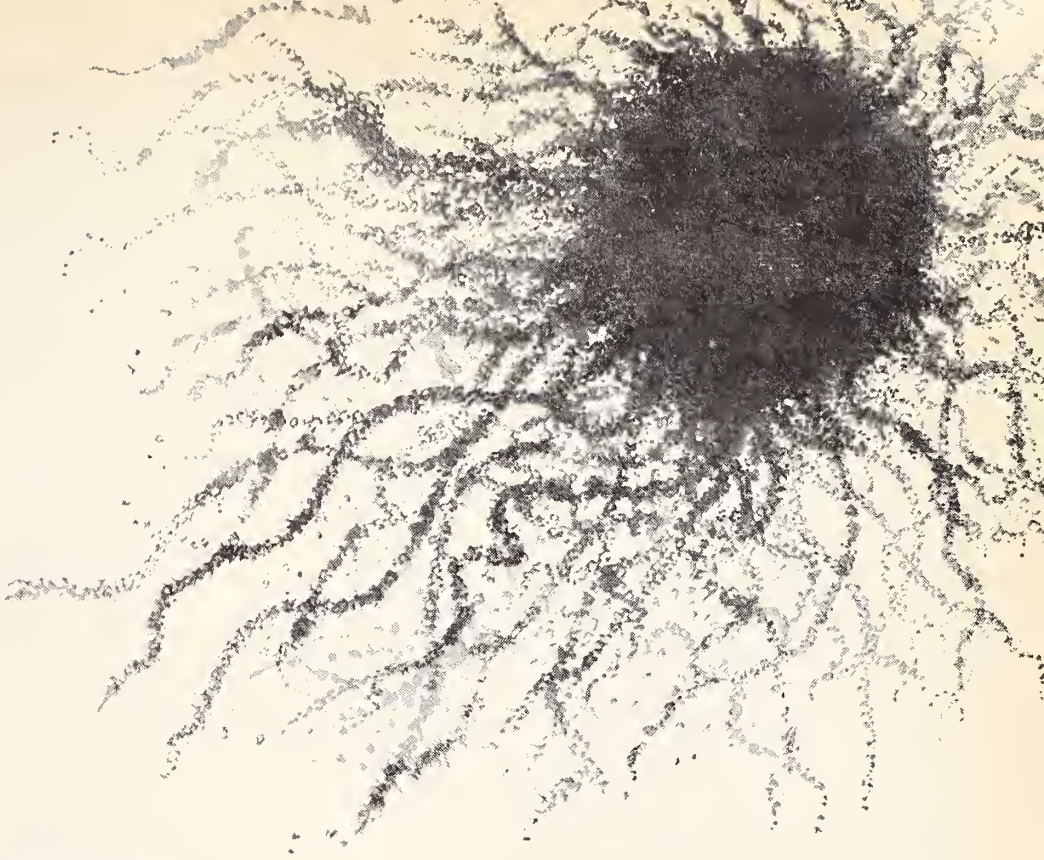
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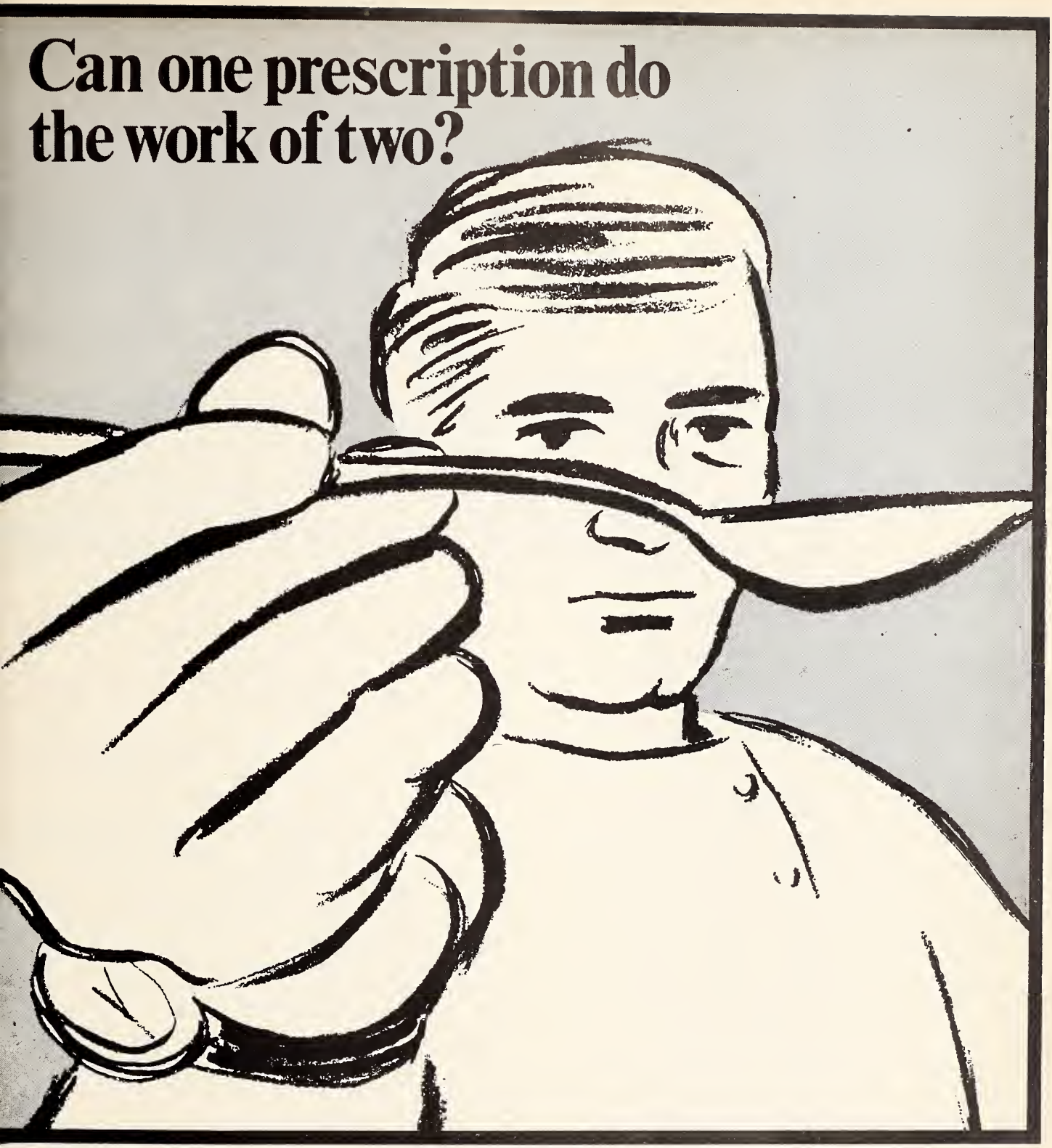
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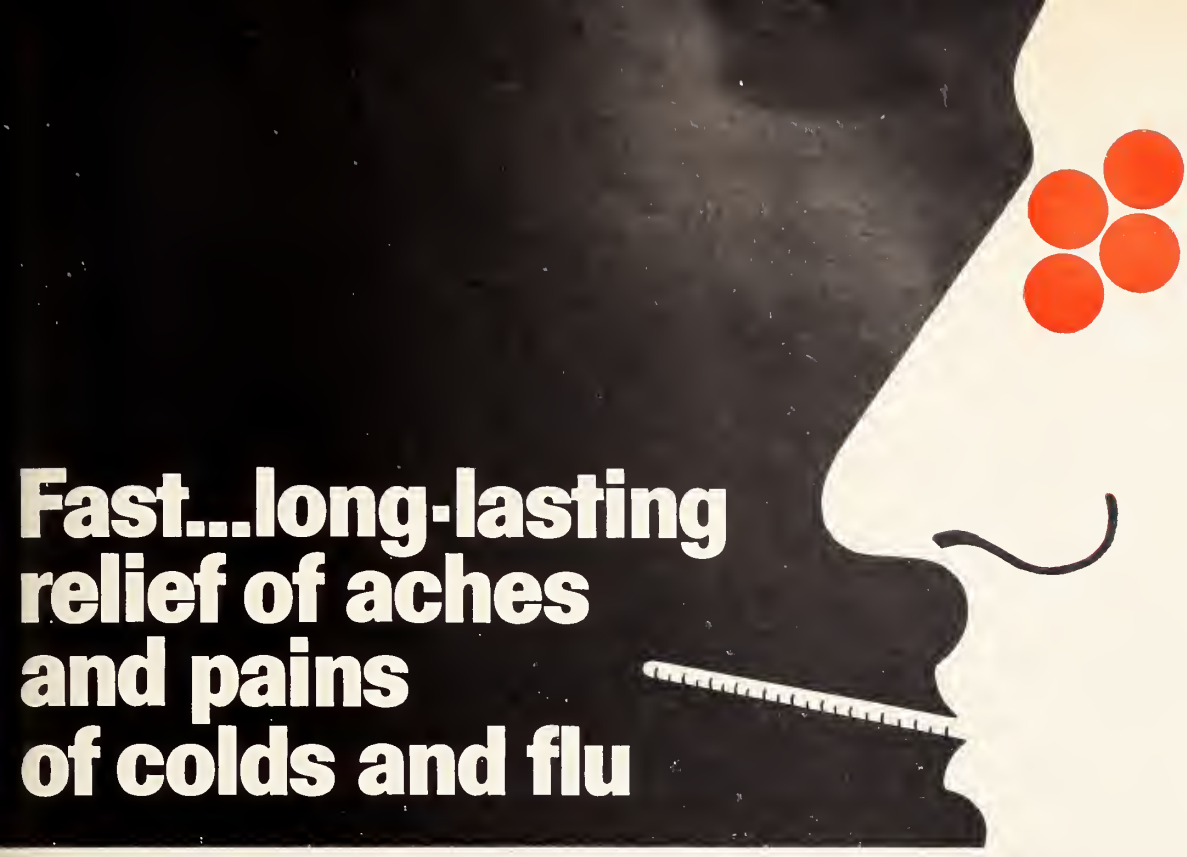
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unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

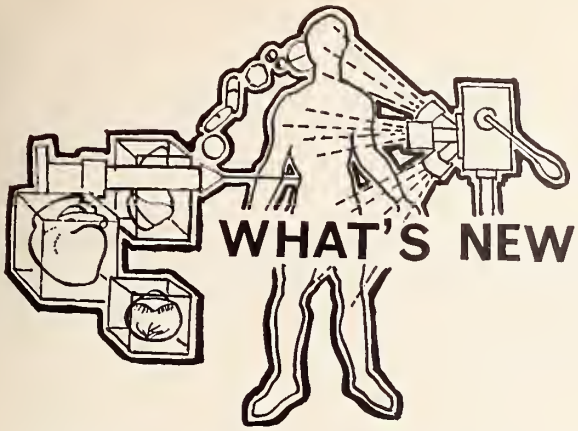
One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

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* * *

An Infant Sentry Apnea Alarm has just been introduced by American Electronic Laboratories. It is a telemetric device which does not require attachment of wires to the infant. An auditory alarm sounds if breathing ceases. The alarm is silenced if breathing is resumed. During normal conditions a blinking light provides assurance of circuit operation. It operates on 110-volt current but has an internal battery which continues to operate for four hours after power failure.

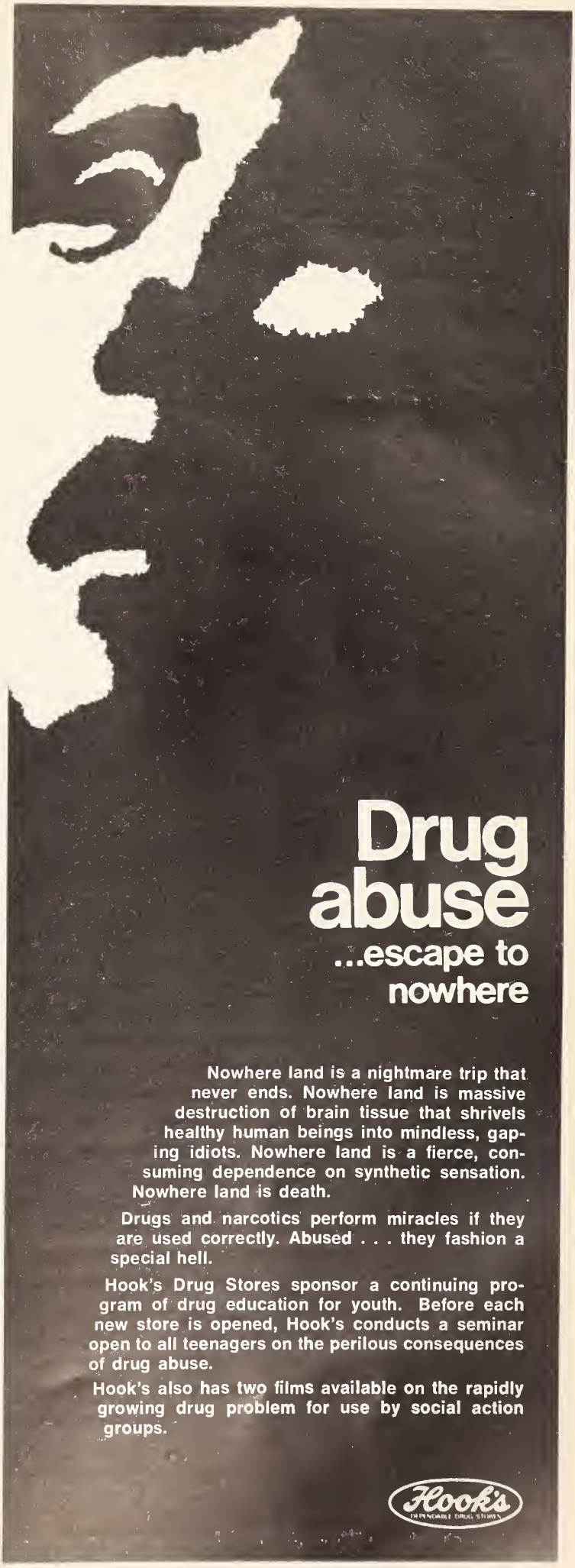
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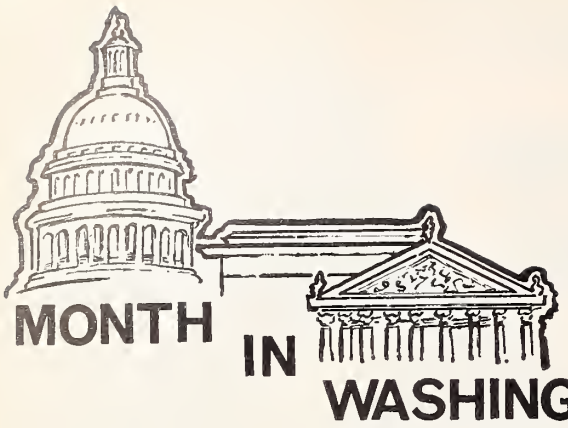
Parke-Davis is introducing a unit-dose package of its antidiarrheal product Pargel. It is marketed in 36-bottle cartons of two ounces each. Each fluid ounce of Pargel contains 6 gm. of kaolin and 130 mg. of pectin.

* * *

The American Academy of Pediatrics has published a comprehensive booklet covering all aspects of child health care written for parents. Entitled "Growing Pains," the 230-page book has information on accidents, bedwetting, bottle feeding, cancer, color blindness, diet, emotional problems, obesity, toilet training and just about everything else. Available at $1 per copy. Address the Academy at 1801 Hinman Ave., Evanston, Illinois 60204.

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.





This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

WASHINGTON, D.C.—The American Medical Association emphasized that the quality of medical care should not be sacrificed for the sake of economy in government health care programs.

DR. WILLIAM O. LaMotte Jr., of Wilmington, Del., chairman of the AMA's Council on Legislation, repeatedly stressed the importance of assuring high quality care in testimony at a Senate Finance Committee hearing on proposed changes in medicare and medicaid.

HE ALSO pointed out the advantages of the AMA's plan for review of physicans' services aimed at holding down costs over an alternative proposal before the committee. The AMA supported a provision of the proposed legislation that would provide for physical therapy services but opposed including chiropractic services under medicare.

DR. LaMOTTE said that there should be pilot projects before a "Health Maintenance Organization" program is started nationwide. A HMO would provide both hospitalization and physicians' services for medicare patients for a set per capita amount.

"THERE ARE questions regarding in-fact cost savings, as well as the quality of health care which may be provided when there are economic incentives to providers to reduce utilization," the AMA spokesman said. "We wish to assure that medicare patients uniformly receive the best quality care.

"TO THIS POINT of quality care, we have one additional concern. As defined in the bill, the HMO may be a 'for-profit' organization and one managed, controlled and operated by lay individuals. Under such circumstances, the incentive for profit and/or lack of the basic essentials of knowledge, training and experience in medical matters could result in the patient being furnished less than the optimum of quality care. To avoid such a result, we recommend that organizations delivering health care should be under the control and guidance of medical personnel."

DR. LaMOTTE also questioned the desirability of a provision that would restrict payments to institutions.

"WILL THIS section create different classes of services based upon the ability or desire of patients to pay for additional services?" Dr. LaMotte asked. "A goal of medicare was to make available to all over 65 persons the same level of health care available to other individuals. Has that goal now been changed?"

HE ASSURED the committee that the nation's physicians as a group "share the concern of the public and the Congress" concerning rising health care costs. But, he said, the AMA must oppose a provision that would substitute an arbitrary statutory limitation on physicians' fees

for the "reasonable" fee now allowed. He said cost factors were too complex for such a simple solution and that the arbitrary limitation would make the medical profession the only sector of the nation's economy under price or wage controls.

AS FOR utilization or peer review, Dr. LaMotte said the AMA objects "most forcefully" to a provision of the pending legislation that would have non-medical groups act as review teams and pass judgement on medical services.

FOLLOWING DR. LaMotte's testimony, the committee modified somewhat the professional review amendment sponsored by Sen. Wallace F. Bennett of Utah, second-ranking Republican on the committee, after he earlier heard an AMA spokesman advocate the peer review principle.

THE MODIFIED version relaxed a requirement for pre-admission clearance to hospitals for elective surgery to leave the matter of such a requirement up to review agencies. But the committee version would permit the Secretary of Health, Education and Welfare to enter into agreements with organizations or agencies other than state medical societies for administering the review programs in areas of 300 or more physicians. The AMA contended strongly that the responsible agencies should be only state medical societies.

MEADE Whitaker, tax legislative counsel for the Treasury Department, asked the committee to add a provision to the legislation that would require health insurance companies and carriers to report unassigned payments to physicians and other providers of health care. Unassigned payments go directly to patients to be given by them to their physicians. A similar proposal was knocked out of last year's tax reform legislation by a House-Senate conference committee.

THE AMA—along with the carriers and HEW—have opposed mandatory reporting by carriers of unassigned payments on the grounds that it would be difficult and costly to furnish the data and that, in many instances, the patient might not have passed along the payment to the physician. This last circumstance unfairly would put on the physician the burden of proving that he did not receive such income.

WHITAKER said the Internal Revenue Service had found that more than half of 3,000 physicians who received $25,000 or more in government medicare or medicaid payments in 1968 failed to report a substantial amount of their income to the tax agency.

THE AUDITS were ordered after the senate committee raised the quesion of whether physicians receiving a large total of annual payments under the government medical programs were paying income taxes on all of it.

"PRELIMINARY results indicate a number of instances of substantial unreported income, including some where the omission exceeds $100,000," Whitaker said.

THE COMMITTEE had turned over to the IRS the names of 11,000 doctors who had received medicare or medicaid payments exceeding $25,000 in 1968. Whitaker said 4,000 of the 11,000 doctors "justified detailed audit" and 3,000 of the audits were nearly complete, and that "about half of the 3,000 we audited will come up with substantial deficiencies" in reported income.

SEN. RUSSELL B. Long (D., La.) said the investigation had disclosed a "vast area of tax cheating" and urged the IRS to initiate criminal prosecutions against doctors who had hidden their medicare or medicaid income.

Continued on page 1277

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Continued

LONG AGREED with the AMA as to NOT including chiropractic services in the medicare program. He told a chiropractic spokesman testifying before the committee:

"INSOFAR as you can convince me that you are doing somebody some good, I would be willing to cooperate, but I am not inclined to cooperate when I am not convinced that you have. My feeling is the only time a chiropractor tried it on me it didn't do any good, so I guess I I am prejudiced by that."

S.4323 NOT PROPER OR WORKABLE APPROACH — VENEMAN

THE NIXON Administration came out strongly against the cradle-to-grave comprehensive national health insurance legislation sponsored by Sen. Edward M. Kennedy (D., Mass.) and supported by organized labor leaders.

JOHN G. VENEMAN, Under Secretary of Health, Education and Welfare, testified before the Senate Committee on Labor and Public Welfare, that the program that would be provided by the legislation "is not a proper or workable approach to the solution of the health problems of this nation" and would cost $77 billion in the first year of full operation.

THE COMMITTEE held hearings on the legislation this year only to publicize it and to provide a forum for its supporters to expound their views. The sponsors resorted to a gimmick—a change in the financing provision—to get it before the labor and public welfare panel after it first was sent to the finance committee which ordinarily handles such legislation. The same maneuver was used in 1949 to get a hearing on President Truman's national health insurance proposal. Kennedy and six co-sponsors of his legislation are members of the labor and public welfare committee.

"THERE ARE those who insist that the present system is sound and should be left alone," Veneman said. "Others demand that we throw out the baby with the bath water and replace our pluralistic health enterprise with some monolithic scheme in which the Federal Government controls everything.

"I THINK both points of view are wrong. The deep troubles of the health care enterprise have been nurtured by many factors, not the least of which is past failure to plan and prepare for the soaring demand that observant people knew was coming. But I do not believe that past neglect means that we now have to start over and pursue some course of action that would be entirely alien to our basic traditions.

"THE CENTRAL issue, over and above the inconceivable commitment of general fund revenues for S. 4323, is whether such a drastic abandonment of existing mechanisms in our health care system is necessary to remedy the defects in the system and whether, in fact, it may not create more problems than it will solve . . . .

"GOVERNMENT is currently purchasing more than 36% of the total output of the health care system. This figure indicates that the use of its purchasing power is probably the government's primary source of leverage to initiate changes in the organization and delivery of health care. As government becomes more involved in financing it also has a greater responsibility to remedy the defects in the system.

Continued

LONG ADDED that, as far as he could see, the AMA "from the ethical point of view on taxes, has been completely forthright and honorable and sought to shield no one."

"THE QUESTION now is whether we should divert revenues needed for income maintenance, nutrition, the environment, housing and other health-related efforts, and concentrate them all on creating the federal system of health financing proposed by S. 4323. To do so would assume the failure of the measures currently proposed to correct defects in the present mixed public-private health system.

"IN SHORT, we (the Administration) have made substantive recommendations for improving the organization and delivery of services, increasing the efficiency of the health care industry, and for stimulating necessary reorganization and redistribution, through financing mechanisms. We are very much aware of the urgent need for solution of many problems in the financing and delivery of care, and have committed ourselves to an insurance program to provide protection to low income families with children.

"HOWEVER, we have serious reservations about the desirability of embarking on a program like S. 4323, that will protect not only the unprotected but those with substantial coverage, and that will radically restructure the health financing and health service industry without having tested the instruments of change." ◀

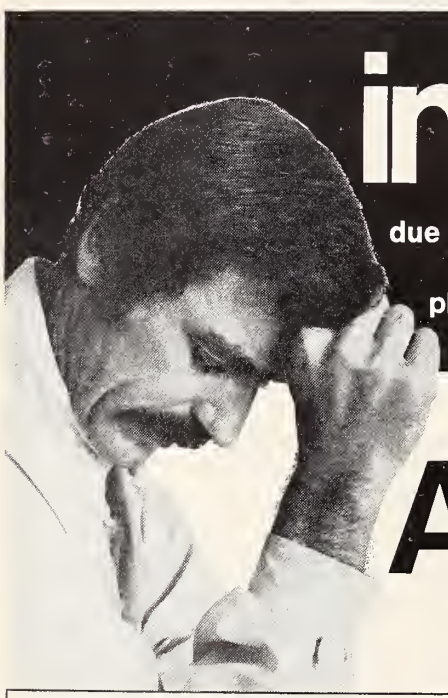
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Official Journal of the American Fertility Society



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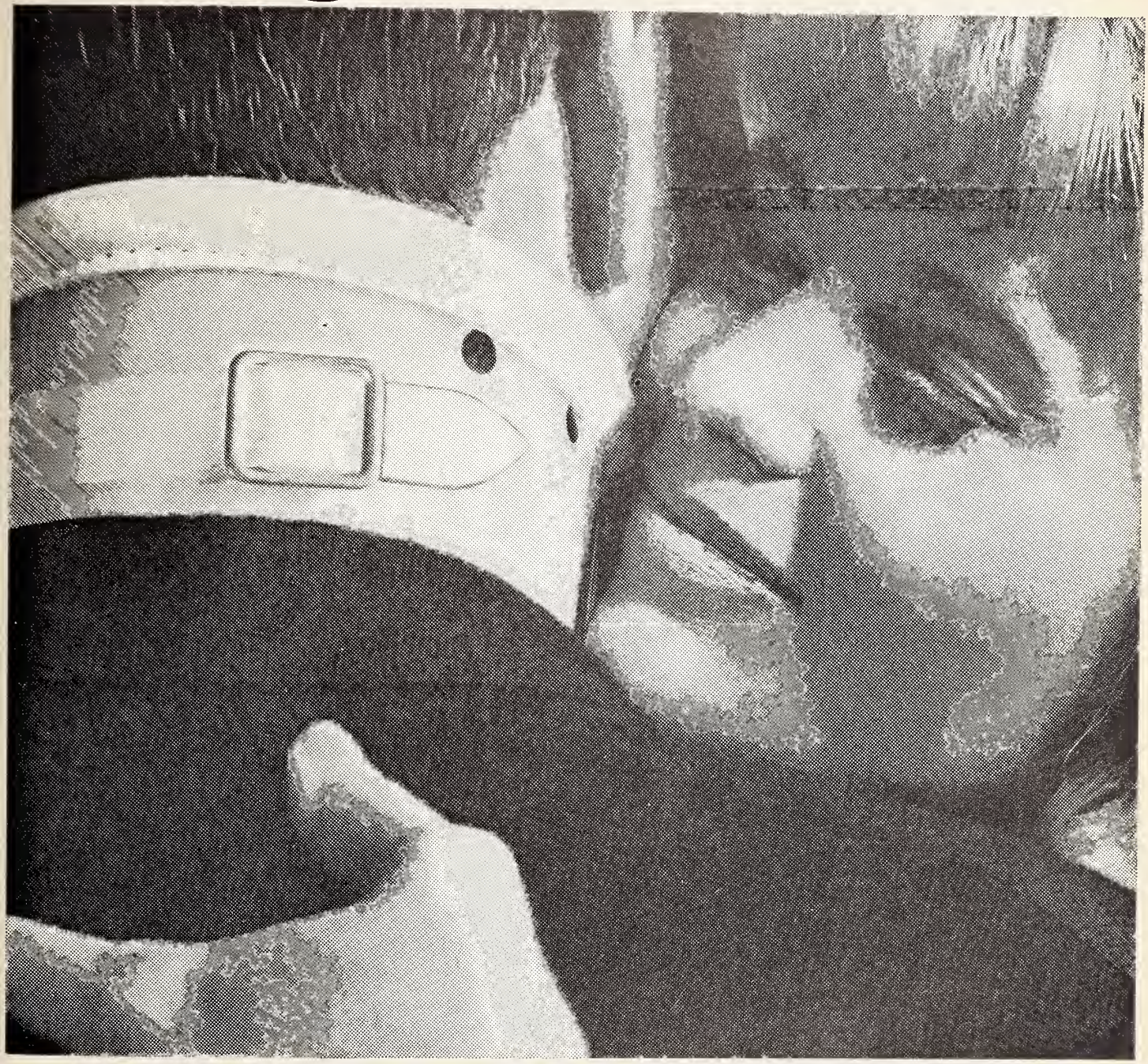
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References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Heilman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. I.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:93 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis J Urol 79:863, 1958. 6. **Dsol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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Medical Education in Evansville—Yesterday Today and Tomorrow

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Evansville

Prologue

THIS is the story of medical education in the Pocket, the name frequently given to the southwestern corner of Indiana over which Evansville presides. It is a story that really began in 1820 and is only today reaching full development in Evansville. Perhaps because of its isolation, Evansville has been singularly dependent upon its own efforts, not only in medical education, but in other fields as well.

During the colorful but sadly overrated 19th century, we had not one, but two medical schools. An intern program was started in Evansville early in the 20th century. Today medical education is not only talked about, but practiced in the Pocket City. Tomorrow? Who can say? But one of our authors has tried his hand at that one.

Yesterday I: From the Beginning to 1890

W. D. Snively, Jr., M.D.

In order for us to take a nostalgic look at medical education in Evansville yesterday, we might briefly review the history of the town. It goes back to March 27, 1812, when Hugh McGary purchased some 200 acres of land from the government. In June 1814, McGary offered 100 acres of his land for the establishment of a county seat. He recommended that the town be named Evansville, in honor of his friend, General Robert Morgan Evans.

That very year, Dr. William Hornby, Jr., completed a long journey from the east, unpacked his saddlebags and proceeded to set up a pioneer practice in the nearby community of McCutchanville. Roads were poor or nonexistent; bridges were few. During high water, streams had to be crossed in dugouts.

The nearest drugstore was in Louisville. The first physician who actually practiced in Evansville was Dr. William Trafton. He arrived in 1820. Then came Dr. Madison J. Bray, Evansville's first surgeon, and Dr. John R. Wilcox, who opened a drugstore on Water Street, now Riverside Drive.

There was not much medical education of any kind in Evansville in those days except that learned by would-be doctors who served apprenticeships under practicing physicians. But in the year 1846 the Evansville Medical College was organized. We still have the graduation diploma that

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hung in the office of Dr. William M. Elliott, graduated in 1853. The Evansville Medical College suspended operations in 1856 because the members simply couldn't get along with each other.

In those days medical colleges were very different from what they are now. The instructors were always practicing physicians, and since they were usually busy, one can imagine that students frequently were forced to wait for the arrival of a preceptor. Many of the early lecture rooms were amphitheaters with steep rising ledges on which were placed chairs for the students. There is reason to believe that students annoyed with late arriving professors sometimes reached the boiling point. In one such amphitheater, at ten minutes past the time appointed for a lecture, the students rose in a body and hurled their chairs down into the central pit. One can suppose that expenditures for chairs might have been an important part of the budgets of those early educational institutions.

Cadavers Scarce

Another fascinating but gruesome aspect of medical colleges of the early days was the problem of obtaining cadavers for dissecting. There was no provision set up for students to obtain cadavers, nor was it even legal to do so, so they had to resort to grave robbing or, somewhat more euphemistically, body snatching. The practice of body snatching is well summarized by an epitaph which appeared on a gravestone in the East:

"The body snatchers, they have
come and made a snatch at
me.
It's very hard—them kind of
men won't let a body be.
Don't come to weep upon my
grave and think that here I be,
They haven't left an atom here
of my anatomy."

The Marine Hospital was built in 1856 at a cost of $73,000. There is not much reason to beleive that very much medical education went on there. It certainly didn't have a D.M.E.

We know quite a bit about the practice of medicine in Evansville in 1858. Over $78,000 was spent for drugs and medicines in that year, and these included alcohol, valerian, ammonia, arsenic, bismuth, atropine, bromine, camphor, digitalis, ergot, iodine, morphine, colchicum and ipecac. And still there probably wasn't very much real medical education in Evansville. The following was said of one of our early respected Evansville physicians, Dr. William Howard Trafton: "He had great force and positiveness of character. . . . His professional convictions were absolute." This attitude, which was probably shared by most physicians, wasn't exactly conducive to medical education.

Medical journals represented one of the chief sources of medical education during the latter part of the 19th century. Evansville certainly had its share. There was the *Western Retrospect of Medicine and Surgery*, established in 1872. It continued publication for but a short time. Then came the *Indiana Medical Reporter*, first issued in 1880. Although popular and well done, its life span was only two years.

In 1870, the Sisters of Charity came to Evansville, purchased the Marine Hospital and renamed it St. Mary's Hospital. In 1873, the Evansville Medical Society was renamed the Drake Medical Society. In 1878, it became the Vanderburgh County Medical Society.

Second College Begun

In 1882, a second medical college, the Hospital Medical College, was incorporated, started by a group of rivals to the Evansville Medical College. This institution had opened again in 1871, only to close in 1884. The Hospital Medical College closed in 1886. Somewhat amusing was the "Seventeenth Annual Announcement of the Medical College of Evansville, Indiana, Session of 1882-1883":

"Besides the regular residents, there is a large floating population always found in the city, presenting a vast variety of human ills, that may be used with profit by the clinical student, many of the cases exhibiting the modifying influence of both Northern and Southern climates on disease, affording a rich harvest of pathology."

Early in the decade of the '90s, 1893 to be exact, what is now Wel-



OFFICE of A. Beatty, M.D., 1863

born Memorial Baptist Hospital had its beginning as the Evansville Sanitarium. From the outset, it conducted a school of nursing, starting out with thirty beds.

Construction of the Southern Hospital for Insane at Evansville was authorized by the General Assembly of 1883. Construction dragged, and admission of the first patients occurred October 30, 1890. The original hospital was to see use until the morning of February 9, 1943, when it burned. First known as Woodmere, the official designation was changed in 1927 to the Evansville State Hospital.



EVANSVILLE State Hospital as it appears today.

Deaconess Founded

Deaconess Hospital saw the light of day on February 22, 1892, when ministers and laymen from a group of churches in the Evansville area founded the institution. Its first home was converted from the residence of former Indiana Governor Conrad Baker. From that house, Clara Barton supervised the first organized flood relief for the American Red Cross in 1884. The institution had 19 beds and was supervised by Sister Mathilda Sterling, a deaconess who came to Evansville from Chicago early in 1893.

Several other hospitals were founded during the closing years of the 19th century.

Outside of the instruction in the medical schools carried out by practicing physicians when they could steal the time from their busy practices, how much medical education went on in Evansville from the early days when the town was founded until the gay '90s? Really, very little. True, some physicians took on young men in preceptorships for a period of two years, during which the student learned something of the practical medicine of the day and did a great deal of work. The sort of medical education they received is well described in *Doctors on Horseback* by James Thomas Flexner when he describes Daniel Drake's work under a preceptor, Dr. William Goforth.

Daniel ground mercury into mercury ointment, memorized Quincy's *Dispensatory*, put up medicines and delivered them. He accompanied Dr. Goforth on his rounds, observing closely what he did. He studied Cheselden on bones and Innes on muscles. He was not supposed to think, only to memorize. He wandered through the humoral pathology of Boerhaave and VanSwieten, and he enjoyed "messing around" in Dr. Goforth's apothecary shop. He mixed ingredients with a metal instrument to make powders that he delivered to the sick, "running full tilt down the streets of the little town, splashing through puddles rather than going around them because you had to be quick like the pony express. And when you knocked on the door of some cabin, with what joy you were greeted by the anxious wife or mother, how eagerly the powder you had prepared was received by frightened hands!"

Daniel slept behind the greasy counter of the apothecary shop. At the age of 19, Daniel Drake, who had never seen a chemical experiment or cut up a human body, became Dr. Drake and shared the leading practice in Cincinnati!

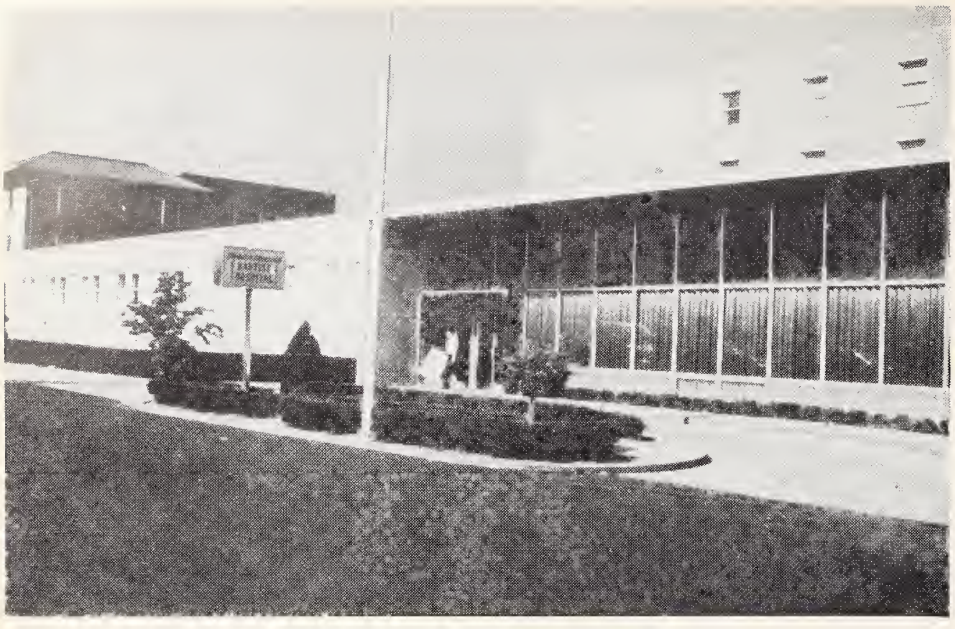
There were certainly staff meetings in the hospitals of the early days, but the amount of continuing medical education that went on then was probably precious little. They were more than likely given over to altercations, in which the doctors of that rude era indulged frequently. Perhaps one reason why there was so little continuing medical education was that there really was so little to learn. Even today medicine is regarded as an art mixed with a science. In those days, it was almost all art. True continuing medical education had to wait many decades for realization.

Yesterday II: 1890-1950

Herman M. Baker, M.D.

In the half century from 1910 to 1960, little was accomplished by way of medical education in Evansville. During this time period, seven hospitals existed in Evansville. St. Mary's, until recently the largest, had begun operation on the riverfront at the foot of Wabash Avenue in what was then the U.S. Marine Hospital. In 1893, St. Mary's occupied a new and very modern, for the time, structure at 700 First Avenue.

The Deaconess Hospital began operation in 1892 at 600 Mary Street.



WELBORN Memorial Baptist Hospital.

and the Evansville Sanitarium was opened in 1895 by Drs. Edwin Walker and A. M. Owen. In 1914, this became known as the Walker Hospital; in 1944, following several name transitions, it became The Welborn Memorial Baptist Hospital. The Hayden Hospital at 20 Walnut Street operated from 1895 to 1935. The Gilbert Sanitarium, 300 Harriet Street, opened in 1895; in 1911, it was rebuilt on Walnut and Riverside, then closed about 1913. The U. S. Marine Hospital, which operated from 1856 to 1872, was later rebuilt on West Indiana Street and closed in 1948. The Evansville State Hospital was opened in 1887 and has grown to 1200 beds. At the time this hospital was built, it was away out in the country; now it is well toward the core of the city.

Intern programs, somewhat irregular in their operation, were started in the first decade of the century. From 1906 to 1950, 36 physicians took internships, 24 at Deaconess and 12 at St. Mary's hospitals. Of these, twelve are currently practicing in Evansville.

The first Department of Pathology was started in 1914 at the Walker Hospital under Dr. Charles Seitz and the first X-ray Department in 1916, also at the Walker Hospital, under Dr. Walter Cleveland. The first X-ray departments at St. Mary's and Deaconess hospitals began about 1917, and the first Departments of Pathology at both St. Mary's and Deaconess began as a cooperative venture in 1924.

Lancet Club Organized

In 1921, The Lancet Club was organized as a physician's luncheon club. It had weekly luncheon meetings where the doctors could discuss their problems and evening meetings once a month, to which all physicians in the Tri-State area were invited to hear a well known guest speaker. During this time, we had from the Mayo Clinic—Charles Mayo, Alvarez, Brash, Buey, Kirklin the Elder, and McCarty the Elder; from Baltimore—Thayer and Bloodgood; from Chicago—B. Sippy, Sol Strouse, J. B. Herrick and Frank Smithies; from Indianapolis—C. P. Emerson, W. Gatch, F. Wyerbacher, Larue Carter, and Bob Moore; from Cleveland—George Crile and John Phillips; from Philadelphia—I. S. Ravdin and A. Stengle; from Ann Arbor—Hugh Cabbott and Frank Wilson; from Topeka—Carl Menninger; and from Louisville—Irvin Abell.

In 1923, The Lancet Club engaged Dr. Frederick Fraenkel of Vienna, who was lecturing in this country, for 10 lectures of two hours each. Dr. Fraenkel lectured on Internal Medicine but emphasized Endocrinology, which was just emerging as a special discipline. After three and a half years, The Lancet Club phased out.

The most successful and stable effort at postgraduate education undertaken was the Clinico Pathological Conference and Grand Rounds at St. Mary's Hospital. This is a Wednesday Morning Conference that attracts visitors from the surrounding area and averages staff attendance of 40, plus about the same number of paramedical personnel. This was begun in 1954 and in the past two years has been linked to the Visiting Professor Teaching Program of Indiana University Medical School.

In 1962, The Welborn Memorial Baptist Hospital developed an educational medium through which practicing physicians continue their education, The Evansville Institute for Continuing Medical Education and Research, Inc. The purpose of The Institute has been carried out through regular seminars treating a wide range of medical topics and through aid to physicians in procurement of resource material for medical research.

Each of the three hospitals has regular Tumor Clinics, and most of the staffs now have some clinical discussion at the regular staff meetings.

Mead Johnson & Company have been most generous and helpful over the years in encouraging and financing efforts at medical education. They have made available for physicians their vast medical library and the advice and assistance of a highly trained research and medical staff.

Today: 1950-1970

W. Thomas Spain, M.D.

The resurgence of postgraduate medical education took place in the 1950's within the community of Evansville. This was brought about

largely by the increase in physician population in both general and specialty practices. The post-World War II physicians had completed their training and were beginning the practice of their chosen fields. The hospitals themselves found they, too, needed to adapt to the increased demand for not only more beds, but new physical facilities to accommodate the needs generated by the discoveries of medical research. Such needs were met by alterations and additions to both Deaconess and Welborn Hospitals and the completion of an entirely new St. Mary's Hospital.

Because of the increased specialization, each hospital's medical education committee took on real significance. Accreditation requirements for hospitals became more meaningful, especially in the education field. The staffs now were departmentalized beyond the conventional medical staff, laboratory, and radiology departments. Each department had monthly meetings not only to transact business, but to review selected patient records as an exercise in continued medical learning.

One hospital (St. Mary's), because of its new physical facility and its medical education committee, petitioned the Council on Medical Education of the American Medical Association to approve a Rotating Internship. Following inspection and recommendation, such a program was approved for postgraduate medical education, to begin on July 1, 1956. This has been the longest, continous, approved postgraduate medical education program in Evansville. The first four years of its operation (1956-1960), eight interns were given postgraduate medical training. It was during this period (1959) that the first externs were trained in Evansville. The externs were required to have completed at least one year of medical school, preferably two, before being employed to work in some medical discipline, usually during their summer vacation. This practice has continued for qualified students.

Foreign Students Trained

A new kind of extern made an appearance in the summer of 1969. By arrangement with the Student American Medical Association, qualified foreign medical students who were in their third or fourth year of training, by our standards, were permitted to train in a medical discipline for academic credit. Five such students have utilized the programs offered in Evansville. The students represented Austria, Switzerland, and West Germany.

During the years 1960-1963, thirteen interns were trained at St. Mary's Hospital.

Since the hospitals' medical education committees were composed of private physicians, it soon became obvious that a permanent or at least part-time program director was essential for the continued success and supervision the postgraduate programs needed. Not only did the supervision of the house staff require such a person, but similar educational programs were being organized and made available for the permanent medical staff.

To assist the medical education committees at the three community hospitals, a monetary education gift to be used over a three year period was made in 1963 to each hospital by Mr. D. Mead Johnson of Mead Johnson and Company. Each hospital was to use the funds to best implement the already existing programs. In March 1963, the first permanent, full-time director of medical education was appointed in Evansville at St. Mary's Hospital. This was Daniel M. Hare, M.D. The second director of medical education was Robert W. Ewer, M.D., who was to direct the programs at Welborn Hospital. Deaconess Hospital elected to continue its program under the direction of the medical education committee, but expanded the medical audio-visual department under the capable and able supervision of Mr. Jack Rusche.

Thus the community's efforts in postgraduate medical education involved three distinct phases—train-



ST. MARY'S Hospital

ing of medical and house staffs, a visiting lecture program, and a medical photography division to be used to illustrate the medical education programs, manuscripts prepared by the staffs and films.

The directors of medical education revised the education programs for both medical and house staffs. Teaching affiliations were established with academic centers—Welborn Hospital with the University of Kentucky Medical Center at Lexington, Kentucky, and St. Mary's Hospital with Indiana University Medical Center at Indianapolis. Local teaching affiliations were made among the hospitals themselves to permit house staff exposure to all the clinical material suitable for teaching purposes. Two additional teaching facilities were brought into the program—namely, the Rehabilitation Center and the Evansville State Hospital.

Medical TV Instituted

In 1967, two new educational programs were instituted to benefit both house staffs and medical staffs. By arrangement with Indiana University Medical Center, closed circuit medical television was instituted. These programs have been presented twice weekly at all hospitals. To bring live consultations, again through arrangements with Indiana University Medical Center, faculty members visit the community once a month to make medical rounds and summarize a medical subject. This is a continuing program ten months of the year.

Special lectures are held each year. The most significant one occurs each February, conducted by the local Academy of General Practice. To share the community wealth of medical teaching material, each quarter the combined staffs of the hospitals meet. This program is rotated among the hospitals, with the host hospital assuming charge of the program. This endeavor has met with much success.

To further use these programs for house and medical staff training, it was decided to video tape the presentations for repeat showing. This was done through the cooperative efforts of all hospitals and needed talents. Hence, a film library has been started.

Reference has been made to the affiliation with Indiana University Medical Center. Because of this, the community medical education programs have been strengthened and permitted us to be participants in the now famous Indiana Plan. Seven clinical disciplines at the senior medical student level have been approved as electives at our hospitals. Others will be added in due course.

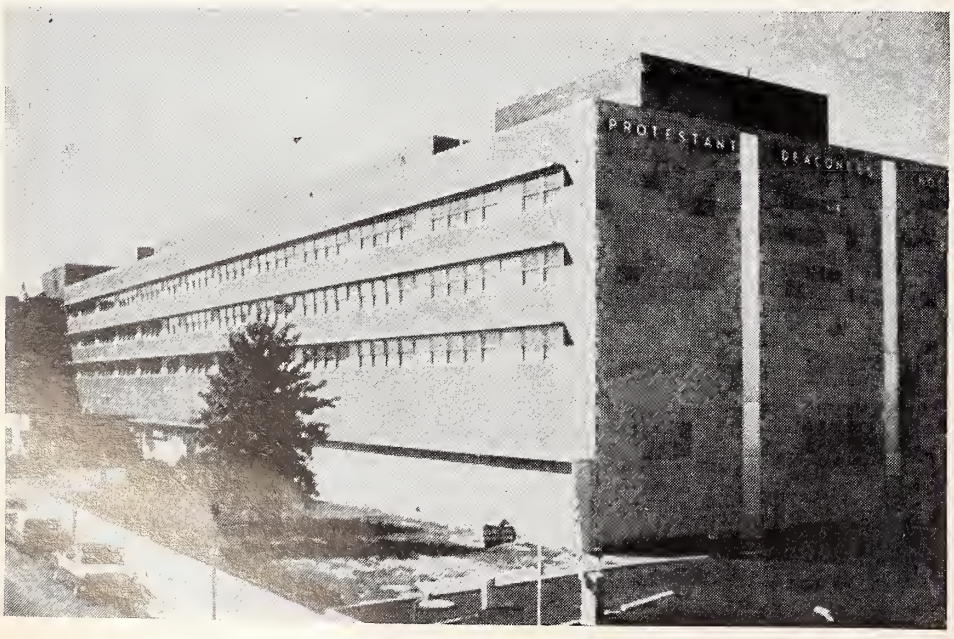
Most people in the state know of Evansville's efforts to establish a medical school. Most people know the proposed plan of the Governor's Commission on Medical Education. We are fortunate that Evansville has been recommended as one of the sites to participate in this plan. The first and fourth years of the medical curriculum will be planned here.

We are not content to stand still. A new Director of Medical Education will assume his duties shortly at Deaconess Hospital. This will complement the already existing programs and new ones will be added.

A full complement of interns is here for postgraduate training. Two new residency programs will be added, one in Family Practice and one in Obstetrics and Gynecology.

How have these efforts benefited the community? Seventy per cent of the interns trained since 1956 have remained or returned to practice in our community. Only 41% elected to become family practitioners; the remainder specialized in internal medicine (15%), in psychiatry (11%), in obstetrics and gynecology (11%), in anesthesiology (7%), in surgery (7%), in pediatrics (4%) and in orthopedics (4%).

The educational efforts of many people have been fruitful. We have a better medical community for it. The programs have played a role in retaining excellent physicians for our community. We will continue our programs, making changes and alterations to meet the medical needs of the seventies.



PROTESTANT Deaconess Hospital

Tomorrow: 1970-?

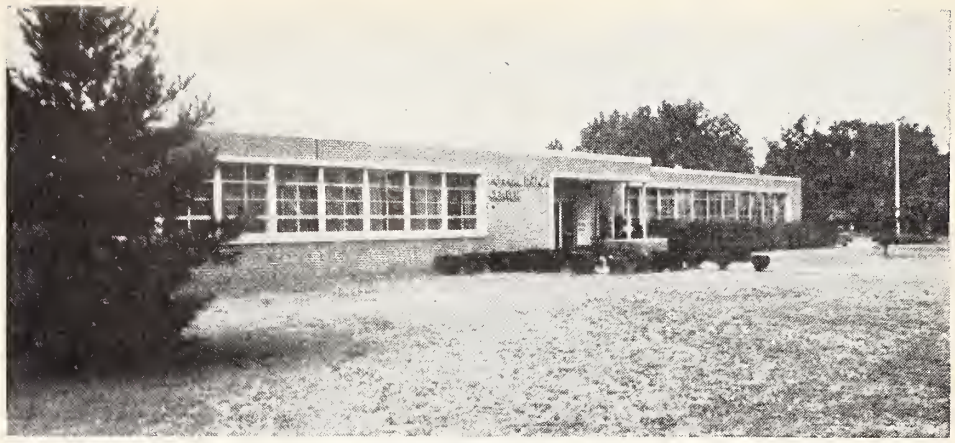
Patrick J. V. Corcoran, M.D.

In considering medical education of tomorrow, we should examine the probable forms of medical practice that will be emerging. Recently the Office of Health Economics of Great Britain's drug industry appointed a panel of medical experts to peer into the future and attempt to forecast medical achievements up to the threshold of the 21st century. Their predictions are titled "Brave New World of Medicine."[1] Among the forecasts:

"The pollution control and 'clean air' policies now being implemented cannot be expected to be completed until 1990; their benefits will be evident by then but 'will not be fully realized until the 21st century.' The range of available antibiotics will increase, and they should be cheaper, more convenient, and in many cases more specific. Effective anti-viral drugs will probably become available during the current decade. By 1980, it's likely that ways will have been found to stimulate the body's own production of interferon.

"The panel members hope that by 1990, 70% of cancers will be controllable—but instead of a single 'wonder' cure, they expect that a number of anticancer drugs will emerge. Some of the more optimistic doctors suggest that fruitful work on enzymes, particularly asparaginase, 'will be carried out between 1970 and 1990.' Research on heart disease will yield results on the effectiveness of cholesterol-lowering medicine by 1975, the panel predicts, but 'no definitive answer' can be expected on dietary changes affecting blood lipids before 1980, if then.

"Finally, by 1990 the aging process will be delayed and even partially reversed, so that there will be a further increase in the average life span."



THE Rehabilitation Center

Future in Evansville

Let us project the future of medical education in Evansville, in particular. The present program of continuing education for practitioners will be expanded with new features and with additional techniques. Periodic self-assessment of current knowledge and skills will enable physicians to update or to strengthen any deficiencies. Two-way TV conferences with medical centers will not only be used for group education, but also will be employed for consultations in difficult, problem cases, often at the patient's bedside.

The various diagnostic and rehabilitation methods developed by the Regional Medical Program will be in full flower with now undreamed-of nuances and by-products. As one example, genetic counseling will be extensively utilized for its predictive and prophylactic potentials.

Training for all health professionals will be offered by a College of Health Sciences, which will include the different schools for physicians, nursing personnel in all echelons, technologists, pharmacists, social workers, and paramedical ancillaries. This will provide means of vertical and lateral mobility for students subsequently desiring to alter their educational programs as their needs and opportunities change.

Evaluative techniques will have been developed to select the best available candidates for the various health careers. The mental, emotional, and motivational qualifications of students will be more precisely determined and an appropriate "student mix" can then be enrolled to meet the probable needs, including those for practitioners, for teachers, and for research workers.

Let us assume that the recommendations of the Governor's Commission on Medical Education are implemented. Medical students will have their initial basic science courses in Evansville, to be followed by medical courses at the Indianapolis Medical Center. They can return here for periods of clinical training in portions of the third or fourth years. Internships will have been supplanted by expanded residency training, and parts of this may be spent in our enlarged general hospital facilities, which by then will probably exceed 1,500 beds devoted

to the acutely ill, supplemented by more than a thousand beds in extended care and nursing-type facilities.

Faculty members from other centers will visit us for short-term sojourns; this will have germinal results in both directions—the local medical community will be enriched, and the visiting teacher will better understand the needs and problems of the particular environment. Practitioners will, in turn, be able to go to the Medical Center for short preceptorships to replenish information or to refurbish skills.

Many of the alterations in health care delivery will change the emphasis on various features of practice compared with the present. Automated history-taking and diagnostic screening procedures will be coupled with team-type activities, involving many different disciplines. There will be more preventive medical care. Geriatric patients will comprise at least 50% of those receiving therapy. Many of the activities now performed by physicians will be delegated among a wide variety of specially trained auxiliary "paramedics," while numerous new technics will demand the physician's own attention. As even more elaborate capabilities for diagnosis or therapy are developed, the personalized one-to-one patient-physician relationship will yield to these less personal ways of achieving effective and definitive benefits.

Health care and services will continue in short supply. Hence, it is unlikely that mandatory retirement limits will be set—this is another advantage which can attract candidates to the profession, for as long as they can function effectively, they will be needed and, indeed, wanted!

Acknowledgement

It is a pleasure to express our appreciation to Jack Rusche, director, Audio-Visual Department, Deaconess Hospital, Evansville, who reproduced the photographs. In addition, the authors gratefully acknowledge the help of Bristol-Myers and Company, which supported certain aspects of this publication. ◄

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A Four Year Study

JOHN D. RALSTON, M.D.*
BENEDICT E. ABREU, Ph.D., M.D.**
Indianapolis

ANIMAL studies[1,2] have shown that the pharmacologic actions of piperacetazine,† a phenothiazine derivative, are similar qualitatively but different quantitatively from those of chlorpromazine. The relative potency of piperacetazine (chlorpromazine = 1) in various pharmacologic and behavioral tests was as follows: depression of conditioned avoidance and reward response in rats, 8; reduction of spontaneous activity in rats, 2.5; potentiation of hexobarbital narcosis in mice, 3.5; "tranquilizing" effect in dogs, 35; protection against amphetamine toxicity, 40; and protection against apomorphine-induced emesis, 50. However, the toxicity of piperacetazine by the intravenous route in mice was half that of chlorpromazine. This profile of activity suggested the utility of piperacetazine as a neuroleptic or tranquilizing agent.

The initial purpose of the present study was to obtain preliminary information on dosage boundaries of this new psychotherapeutic agent, which would serve as a guide for clinical investigators undertaking studies elsewhere. Later, the goal was extended to a long-term clinical evaluation. The effectiveness of piperacetazine in acute and chronic schizophrenia and the infrequency of complicating side effects have already been established.[3-8] This report summarizes observations made during four years of continuous use of piperacetazine in a typical state hospital.

The service on which this long-term study was made consists of three administratively integrated hospital units: a security area providing maximum supervision of disturbed patients; a closed area for the institution of occupational therapy and limited privileges; and an open-house area for patients requiring minimal restriction and supervision, and where each patient has some occupational activity. From this last unit, those patients who are competent to do so acquire employment in the community while still residing in the hospital—a "half-way house" arrangement that is a prelude to trial on convalescent leave and eventual full rehabilitation. Many patients cannot reach this ultimate goal, and for these a good adjustment to hospital life and routine at some level of this program must be considered a successful therapeutic result.

The service is set up to receive, manage, and treat the most disturbed, physically competent male patients admitted to this large mental hospital and, whenever possible, to rehabilitate them. Even so, only about 30% of the patients on the service receive tranquilizers, as compared to nearly 50% for the hospital as a whole. All forms of active and intensive therapy are employed in an effort to effect remission of symptoms, improve personal behavior, better interpersonal relationships, and arouse interest in occupational and recreational activities. Patients in all degrees of mental illness can remain for protracted periods under the care of the same team of observers. This provides an opportunity to observe the long-term effect of psychotherapeutic drugs.

The results observed during the first 60-90 days of the pilot study were sufficiently encouraging to justify a broader evaluation. Consequently, all other psychotherapeutic agents were removed from the test area and piperacetazine was employed exclusively to replace chlorpromazine, promazine, and trifluoperazine, the principal drugs then in use. After 23 months, when supplies of piperacetazine became short, this agent was removed from the secure area, and patients on that unit were returned to chlorpromazine. This unplanned, but necessary, sequence of drug use provided additional criteria for comparison of the two agents.

Methods

Piperacetazine was given in the

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* From the Indiana Central State Hospital, Indianapolis. Dr. Ralston is now Chief of Clinical Services, Colorado State Division of Corrections, Canon City.

Dr. Abreu was with The Dow Chemical Company at the time of the study and, later, with the Department of Pharmacology, University of Texas Medical School, Dallas.

** Deceased.

† Supplied as QUIDE® by The Dow Chemical Company, Indianapolis.

following dosage forms: a parenteral solution (2 mg./ml.) for intramuscular injection; an elixir (10 mg./5 ml. teaspoonful) for oral administration; and tablets (10 and 25 mg.). Patients new to the study were usually started on piperacetazine in milligram dosages of one-tenth to one-twentieth of their previous maintenance chlorpromazine dosage. Through experience we found that if the initial oral dosage of piperacetazine did not exceed 10 mg. q.i.d., orthostatic hypotension was not a problem. After a few days, dosage could be readily increased until the desired therapeutic effectiveness was attained. Some patients were given an initial intramuscular dose of 2 mg. of piperacetazine, and some were maintained for a short while on intramuscular doses exclusively (not exceeding 4 mg. per dose four times daily).

Laboratory studies made at intervals for most of the patients included complete blood counts, urinalyses, and liver function tests (icteric index and thymol turbidity). Serum cholesterol and cephalin flocculation tests, and bilirubin (indirect van den Bergh) tests, were made in a limited number (43) of patients.

In the second year of the study, 87 of the patients were examined retinoscopically by a consulting oph-

CLINICAL RESULTS WITH PIPERACETAZINE IN SERIES OF MALE MENTAL PATIENTS (AFTER 2 1/2 YEARS)

Diagnostic Classification	Marked Benefit	Some Benefit	Little or No Benefit	Total No. Patients
Mental deficiency with psychotic reaction	6	1	1	8
Schizophrenic reaction:				
schizo-affective type	2	...	...	2
acute undifferentiated type	1	2	...	3
chronic undifferentiated type	9	6	1	16
simple type	4	3	...	7
catatonic type	13	4	...	17
hebephrenic type	4	4	2	10
paranoid type	23	19	3	45
residual type	...	1	...	1
juvenile type	1	...	...	1
Chronic brain syndrome associated with:				
convulsive disorder	3	1	...	4
CNS syphilis	3	6	...	9
brain trauma	1	...	...	1
alcohol intoxication	4	4	...	8
intracranial infection other than syphilis	1	2	...	3
Psychoneurotic reaction:				
anxiety reaction	...	1	...	1
Involutional psychotic reaction	1	...	...	1
Manic depressive reaction:				
manic type	2	1	...	3
depressed type	2	1	...	3
Sociopathic personality disturbance:				
drug addiction	1	4	...	5
Paranoia	2	1	...	3
Personality trait disturbance	1	...	1	2
Totals	84	61	8	153

TABLE 1

thalmologist (J. W. Reuter, M.D.). These included the youngest and oldest, as well as the shortest and longest duration of illness, and the averages were almost identical with those of the entire series. At the time of the ophthalmoscopic examination, they had been treated with piperacetazine for periods of one to 22 (average 17) months.

Results and Discussion

This study was to have terminated at 2½ years, and at that time 153 detailed case records and an analysis of our results were supplied to the sponsor for new drug approval purposes. The distribution of patients by diagnostic classification is shown in Table 1; the age of these patients, the estimated duration of illness, the duration of piperacetazine therapy and the daily dosage are shown in condensed form in Table 2. Approximately one-third of the original group of patients was continued on the drug and 44 patients continued to receive piperacetazine for over 36 months to a maximum of four years without interruption. During the full four-year study period piperacetazine injectable (2 mg./ml.) was the only phenothiazine given parenterally.

Extrapyramidal Signs—Parkinson-like signs and other evidence of extrapyramidal tract involvement did not persist as side effects of piperacetazine in the dosage range that we found to be therapeutically effective and adequate. We did not, therefore, have occasion to employ antiparkinson drugs in connection with our use of piperacetazine.

For the initial trial some 20 male patients were selected. Each was on a maximum tolerated chlorpromazine dosage, but none was being adequately controlled and each exhibited some degree of extrapyramidal tract effect. Chlorpromazine was discontinued and piperacetazine started in milligram dosages of one-twentieth to one-tenth of the chlorpromazine dosage. During the next two years, psychiatric symptomatology remained either much the same or showed some improvement, but the most impressive result was the clearing of the extrapyramidal signs. When, as already noted, supplies of the drug became limited, we discontinued piperacetazine (except the injectable dosage form) in the secure area of the service. Within 15 to 60 days after resumption of chlorpromazine in the original dosage, development of extrapyramidal tract involvement was evident. There was also a tendency of the psychiatric condition to relapse in those patients who had improved on piperacetazine therapy. Remission to some degree of the extrapyramidal signs was effected by reduction of the chlorpromazine dosage, in most instances by one-half. Control of the psychiatric condition was maintained by supplementing the reduced chlorpromazine dosage with piperacetazine, 2 mg. given intramuscularly daily or every other day and as needed for episodes of acute disturbance. Two patients, on resumption of chlorpromazine, developed extrapyramidal tract signs to a very marked degree. This drug was discontinued, and both patients were returned to piperacetazine alone. As before, both patients showed rapid improvement in reduction of extrapyramidal symptoms, while maintaining control of psychiatric symptoms.

Weight Gain—Most patients on piperacetazine maintained their starting weight or gained, but this gain presented less of a problem than the weight gain observed generally with chlorpromazine. The few really excessive or pathologic gains occurred in physically inactive patients—

INTERIM ANALYSIS (AFTER 2 1/2 YEARS) OF PATIENTS ON PIPERACETAZINE THERAPY

Age of Patients		
	Oldest	69 years
	Youngest	14 years
	Average Age	40.7 years
Estimated Duration of Illness		
	Longest	40 years
	Shortest	1 year
	Average Duration	13.7 years
Duration of Uninterrupted Therapy		
	Longest period of use	28 months
	Shortest period of use	2 months
	Average treatment period	19.2 months
Total Daily Dosage*		
	Highest daily dosage	160 mg.
	Lowest daily dosage	5 mg.
	Average dosage	44.7 mg.

* Most frequent dosage schedule employed was q.i.d. (8-12-4-8)

TABLE 2

"ward sitters" who could not be motivated.

Patients on piperacetazine were generally less sedated than by chlorpromazine, and since they were free of the parkinson-like symptoms so frequently associated with the latter drug, they were more readily motivated to participate in occupational therapy assignments. This might account for the fewer instances of weight gain seen.

Sedation—Excessive sedation, on a service such as described, is an undesirable side effect when it persists to the point of interference with therapeutic goals. As our experience with piperacetazine increased, we came to consider excessive drowsiness, or daytime sleeping, as a directive or indication for prompt reduction of dosage. Such symptoms, or side effects, generally developed only after agitation and other psychiatric symptomatology had receded, thus justifying a lower maintenance dosage. Chlorpromazine therapy, in dosage adequate to effectively quiet certain of these patients, had been complicated by drowsiness that for some approached the point of semistupor.

Photosensitivity—No evidence of photosensitivity was observed, even though most of the treated patients were at some time exposed to intense sunlight.

Habituation-Addiction-Withdrawal—No habituation and no addiction to any degree with piperacetazine was evident to us during the four years of study. Sudden withdrawal of the drug, in the largest dosage given for the longest period of administration, did not precipitate any identifiable withdrawal symptoms or complaints. There was no evident upsurge of anxiety following sharp discontinuance of medication which might indicate incipient drug dependency. There were no convulsive episodes associated with treatment or sudden withdrawal of piperacetazine.

Patient Acceptance—Chlorpromazine concentrate, for some time prior to this study, was the drug principally used, and was the source of a great deal of patient resistance. The piperacetazine elixir, taken with or without dilution by water, seemed more acceptable to patients since objections were rare. Some of the patients on the described service were unusually difficult at best, and we consider that to some extent the improved ward conditions under piperacetazine therapy may well have been due to the lack of conflict at "medicine time" and to less medication being discarded or rejected by the patients.

Anorexia—The appetite of patients on piperacetazine generally showed improvement regardless of dosage form employed, and whether given either before or after meals.

Kidney Damage—Nothing was observed during the course of the study period which suggested that the drug in any way adversely affected kidney function. Urinalysis was a routine procedure.

Retinitis—In the 87 patients who had received piperacetazine for nearly two years and were examined for evidence of retinitis pigmentosa, none was found. Altogether, 136 patients, male and female, were examined by our consulting ophthalmologist and no pathology was found.

Liver Function—No abnormal physical findings were noted, and the results of special liver function tests cited above did not exceed normal range.

Orthostatic Hypotension—In the dosage that we employed, orthostatic hypotension was not a problem. In fact, we believe we had less trouble in this regard than we have had with patients maintained on high dosage of other phenothiazines. Serious syncope was encountered on only one occasion, and that occurred in a nonpsychotic, healthy 19-year-old male, given 5 mg. of piperacetazine by intramuscular injection. The drug, in lesser amount, 2 mg. per dose, has been given many times by that route to psychotic patients without syncope. An initial dose in excess of 2 mg. intramuscularly can be expected to cause a symptomatic hypotension in susceptible patients. In our experience, after administering several thousand intramuscular injections, we found that 2 mg. is very well tolerated. It should be noted that patients who have been on piperacetazine for a week or more, whether administered orally or by intramuscular injection, have significantly less tendency to exhibit this potential hypotensive effect.

Before the end of the first week of the pilot study, we were aware that large initial doses of piperacetazine could produce severe postural hypotension. Tolerance to the hypotensive effect develops rapidly; therefore, we started with 0.5 to 1 mg. initially, gradually increasing over four days, to an average of 2 mg. per dose for the desired psychotherapeutic level. Transfer of the patient to oral medication was effected as soon as possible and parenteral medication was then used as a supplement when necessary until maintenance levels could be established. Piperacetazine is a potent drug and when employed judiciously, it appears to be exceptionally free of major side effects. When given unwisely (in large initial doses) to a particularly reactive person (especially a "normal" or nonpsychotic person) a postural hypotension to a dramatic degree can

Generic and Trade Names of Drugs

Chlorpromazine—**THORAZINE**
Diphenylhydantoin—**DILANTIN**
Piperacetazine—**QUIDE**
Primidone—**MYSOLINE**
Promazine—**SPARINE**
Trifluoperazine—**STELAZINE**

occur. We found it easier to avoid postural hypotension and related syncope than to relieve the anxiety and fears of the patient when he relates such an experience to drug therapy.

Dryness of Mouth—This reaction, often associated with the use of drugs of this type, seemed less evident with piperacetazine. At one time we felt that this might be a local, or surface, effect. However, for two years we had the opportunity to observe daily a private, nonpsychotic patient who was fed and medicated by gastrostomy tube with no oral contact with piperacetazine. The secretion of saliva decreased within five or ten minutes after 5 mg. of the drug was introduced into the stomach. The effect continued for about 1½ hours and then there was a gradual recovery to normal flow without an excessive or rebound effect. For this purpose and in this dosage, piperacetazine was fully effective over the two year period. An occasional patient commented on "dryness of mouth" but no one complained to the point of interference with long-term therapy.

In Conjunction with Electroconvulsive Therapy—Piperacetazine has been useful for maintenance of the remission brought about by electroconvulsive therapy. This drug, both orally and intramuscularly, was employed on the "off days" during electroconvulsive therapy as an effective chemical restraint of severely disturbed patients.

In Conjunction with Anticonvulsant Therapy—Piperacetazine was given to all patients on this service (varying in number from six to ten) whose convulsive disorder was complicated by severe emotional instability and violent episodic outbursts. The results, generally, were gratifying, as some marked benefit was seen in each instance. The drug does not appear to potentiate any specific anticonvulsant, but serves rather to tranquilize or reduce irritability and emotional tension. Piperacetazine has been taken along with diphenylhydantoin and primidone for one to four years by patients with convulsive disorders.

Tissue Tolerance to Injection—We have given several thousand injections of piperacetazine in doses of 1 and 2 mg. and up to 4 mg. in some instances, with negligible local tissue reaction. Up to 100 consecutive daily intramuscular injections have been given the same patient. To further check local tissue reaction, up to a dozen single 2 mg. doses in as many days were given subcutaneously in an area of the upper arm, no more than an inch in diameter, with development of only slight local tenderness.

Dosage Range—In our experience, the dosage of piperacetazine, initially and subsequently, must be individualized, with an initial oral dose not exceeding 10 mg q.i.d. Some patients were started on an oral dose of 20 mg. daily, but none on more than 40 mg. per day. In the highly disturbed patient, oral medication was supplemented by one or two daily (a.m. and/or p.m.) intramuscular doses of 1 mg. to 2 mg. This regime will bring many patients under satisfactory control in three to five days and permit a low oral dosage to be continued for maintenance without further adjustment. After three to five days, the oral dosage can usually be doubled and even tripled, when necessary, without complicating side effects. In general, however, it is our belief that the smallest dosage that will effect the desired therapeutic result in a reasonable time is more appropriate than excessive dosage that can increase the potential for undesirable side effects.

Subcutaneous or intramuscular injection of piperacetazine is particularly useful for control of the difficult-to-manage patient. An injection of 1 to 2 mg., and occasionally up to 4 mg., will usually subdue highly overactive and aggressive psychotic males within 15 to 20 minutes. It is frequently possible to gain their cooperation with oral medication after the first or second parenteral dose.

The injection dosage form appears especially advantageous as a supplement to piperacetazine and to other phenothiazines given orally. By providing a potent and almost immediate therapeutic effect, when the need arises, the injectable material can temporarily accomplish a more complete "phenothiazination" with a minimum of total drug.

Summary

In a study of four years duration, involving 153 hospitalized patients, piperacetazine was judged to be a potent agent for control of agitated, psychotic patients. On a weight basis, 1 mg. of oral piperacetazine is generally as effective as 10 mg. of chlorpromazine, and in some patients the ratio is even greater. The incidence of side effects, however, is substantially less with piperacetazine. We found the average daily maintenance dosage of piperacetazine to be 44.7 mg., which in our experience is roughly equivalent to 500 mg. of chlorpromazine. At this dosage level, side effects rarely interfered with piperacetazine therapy. Our highest daily dosage of piperacetazine (160 mg.) could theoretically be the equivalent of 1600 mg. or more of chlorpromazine. In certain patients on piperacetazine at such dosage levels (160 mg. daily) extrapyramidal signs previously induced by chlorpromazine at doses of 400 to

800 mg. daily actually disappeared. Therapeutically, piperacetazine and chlorpromazine would appear to differ very little, but the low incidence of side effects appears to be a notable advantage of the former and permits more intensive medication when needed in the management of patients with chronic mental disorders. Piperacetazine injection (subcutaneous or intramuscular) causes minimal tissue irritation and is highly effective in small dosage.

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ELECTROCARDIOGRAM OF THE MONTH

Complete Heart Block in Myocardial Infarction

CHARLES FISCH, M.D.
*Indianapolis**

THERE is considerable confusion as to what represents complete heart block in patients with myocardial infarction. This discrepancy leads to a wide variation in the reported incidence as well as survival rates of patients with "complete" heart block, a proper diagnosis of utmost importance because it will determine the course of therapy, particularly where pacemakers are involved.

The accompanying figure is an example of such a dilemma. The atrial rate is 50 and the ventricular (QRS) rate is approximately 55-60, there is a lack of temporal relationship between the P and QRS and many would diagnose this particular tracing as complete infarction. There are three features which mitigate against such a diagnosis.

(1) The atrial rate is slower than ventricular thus junctional (AV nodal) escape rhythm must be suspected.

(2) Whenever the P wave arrives after the refractory period (e.g. second P and third QRS in lead II) it conducts with a reasonable P-R indicating that the conduction is intact.

(3) Furthermore, the normal QRS, the rate of 55-60 and the inferior (posterior) infarct, all indicate that the rhythm is A-V nodal (junctional).

This type of disturbance of rhythm carries with it an excellent prognosis, usually responds to atropine or isoproterenol (Isuprel[R]) and never requires pacemaker therapy. ◄

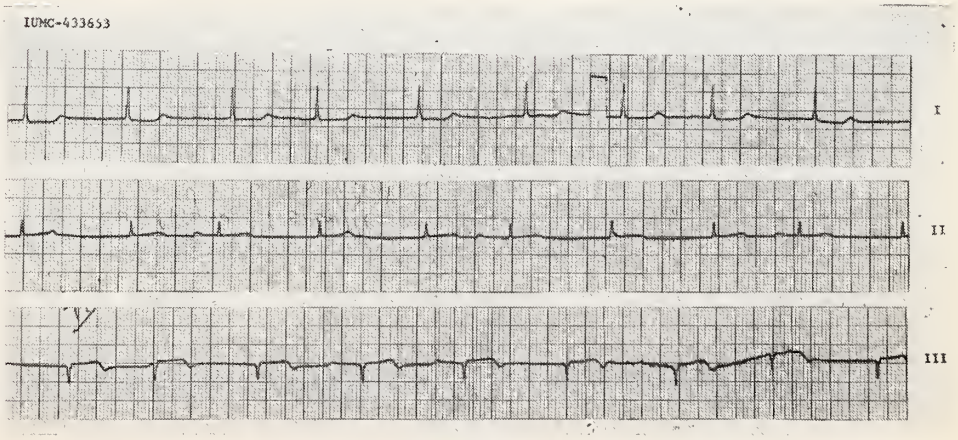


FIGURE 1
INFERIOR infarct, sinus suppression with junctional (A-V nodal) rhythm (for details, see text).

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.


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*Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

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for the treatment of solar/actinic keratoses... a topical alternative to conventional therapy

Fluorouracil—the Roche contribution

In 1962, Roche Laboratories introduced Fluorouracil Roche® (5-fluorouracil). Early clinical work with this drug suggested that it possessed a selective cytotoxic activity when applied topically to certain kinds of lesions. Based on this work and years of clinical trials, a standardized form of topical fluorouracil can now be recommended for treatment of multiple solar or actinic keratoses.

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Efudex presents the physician with a topical alternative to surgery in the treatment of solar or actinic keratoses. It is effective, comparatively inexpensive and especially well-suited for treatment of multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

Highly effective on first and later applications

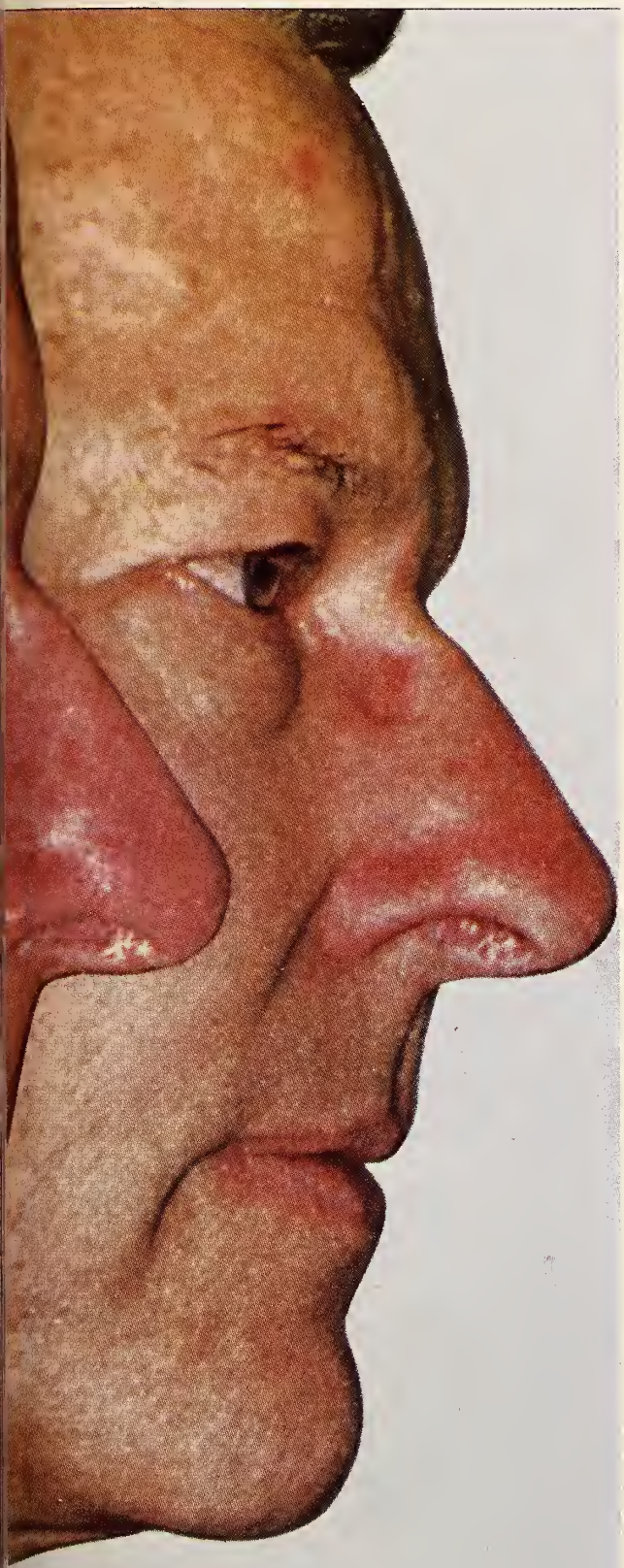
In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When lesions did recur or new ones appeared, repeated courses of Efudex therapy proved effective.*

1/22/68—Treatment with 5% 5-FU cream commences. Patient K.L. showing widespread but mild solar keratoses (also known as actinic keratoses).



2/2/68—After 11 days of treatment. Erythema is seen at site of keratoses. In addition, numerous lesions not apparent prior to therapy have become manifest by sharply defined reactions. Intervening skin, also treated, shows no response to therapy.

2/19/69—One year after cessation of therapy. Skin appears clear with no evidence of scarring. Examination reveals lack of recurrence or the formation of new lesions.



Predictable sequence of therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of the keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two to three months before gradually receding.

Selective—with a high degree of safety

Despite the temporary unsightliness and discomfort of the inflammatory episode, Efudex is, in general, more readily tolerated than surgery. Clinical work shows the intense inflammatory response to be limited to the area of the lesion. Normal skin is not similarly affected. Another measure of Efudex safety: systemic absorption of topical fluorouracil was insignificant, indicating a low risk of systemic toxicity.*

Two strengths—two convenient dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, there are two important considerations. First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

2% and 5% Solutions; 5% Cream Applied twice daily—resolves solar or actinic keratoses.

new Efudex® (fluorouracil) cream/solution



For full prescribing information, please see the following page.

Roche introduces

Efudex®

(fluorouracil) cream/solution the new standardized topical for solar/actinic keratoses

Description: Efudex solutions and cream are topical preparations containing the fluorinated pyrimidine 5-fluorouracil, an antineoplastic antimetabolite.

Efudex Solution consists of 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris-(hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Actions: There is evidence that the metabolism of fluorouracil in the anabolic pathway blocks the methylation reaction of deoxyuridylic acid to thymidylic acid. In this fashion fluorouracil interferes with the synthesis of deoxyribonucleic acid (DNA) and to a lesser extent inhibits the formation of ribonucleic acid (RNA). Since DNA and RNA are essential for cell division and growth, the effect of fluorouracil may be to create a thymine deficiency which provokes unbalanced growth and death of the cell. The effects of DNA and RNA deprivation are most marked on those cells which grow more rapidly and which take up fluorouracil at a more rapid pace. The catabolic metabolism of fluorouracil results in degradative products (*e.g.*, CO_2, urea, α-fluoro-β-alanine) which are inactive.

Studies in man with topical application of ^{14}C-labeled Efudex demonstrated insignificant absorption as measured by ^{14}C content of plasma, urine and respiratory CO_2.

Indications: Efudex is recommended for the topical treatment of multiple actinic or solar keratoses.

Contraindications: Efudex is contraindicated in patients with known hypersensitivity to any of its components.

Warnings: If an occlusive dressing is used, there may be an increase in the incidence of inflammatory reactions in the adjacent normal skin.

Prolonged exposure to ultraviolet rays should be avoided while under treatment with Efudex because the intensity of the reaction may be increased.

Usage in Pregnancy: Safety for use in pregnancy has not been established.

Precautions: If Efudex is applied with the fingers, the hands should be washed immediately afterward. Efudex should be applied with care near the eyes, nose and mouth. To rule out the presence of a frank neoplasm, a biopsy should be made of those areas failing to respond to treatment or recurring after treatment.

Adverse Reactions: The most frequently encountered local reactions were pain, pruritus, hyperpigmentation and burning at the site of application. Other local reactions included dermatitis, scarring, soreness and tenderness.

Also reported were insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity and lacrimation.

Laboratory abnormalities reported were leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Efudex should be applied twice daily with a nonmetal applicator or suitable glove in an amount of the solution or cream sufficient to cover the lesion. When Efudex is applied to a lesion, a response occurs with the following sequence: erythema, usually followed by vesiculation, erosion, ulceration, necrosis and epithelization. The lower frequency and intensity of activity in adjacent normal skin indicate a selective cytotoxic property. Medication should be continued until the inflammatory reaction reaches the erosion, necrosis and ulceration stage, at which time use of the drug should be terminated. The usual duration of therapy is from 2 to 4 weeks. Complete healing of the lesion may not be evident for 1 to 2 months following cessation of Efudex therapy.

How Supplied: Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Clinical Studies: The effectiveness of the three preparations as determined by complete involution of solar keratoses was: 2% Solution, 77% of 282 lesions; 5% Solution, 88% of 202 lesions; and 5% Cream, 85% of 189 lesions. In those lesions where complete involution followed treatment, the rate of possible recurrences observed clinically at periods up to 12 months or more was: 2% Solution, 4.6% of 218 lesions; 5% Solution, 1.7% of 177 lesions; and 5% Cream, 5.6% of 160 lesions. Because of the toxic potential of fluorouracil, some physicians preferred to use the 2% solution when large areas were to be treated. Approximately 30% of the lesions required treatment for two weeks or less; approximately 78% required four weeks or less for adequate treatment.

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X-RAY CONFERENCE

Traumatic Carotid-Cavernous Sinus Fistula

*MARY WOOD, M.D.**
*LOYD C. MEGISON, M.D.***
*WILLIAM L. NORWOOD***
*ERICH K. LANG, M.D.**

THIS 63-year old Negro male (70-279584) sustained trauma from a "tire tool" to the right head and face resulting in fractures of the right orbital floor, right mandible, right zygomatic arch, and traumatic uveitis of the right eye. He was unconscious for ten to twelve hours. On admission to the hospital, his vital signs and physical findings were unremarkable other than the described facial injuries and diaphoresis. Neurologic examination was likewise negative.

Carotid arteriograms revealed a carotid-cavernous sinus fistula on the right side. The right hemisphere appeared to derive its predominent supply from the left carotid via the anterior communicator, a finding which was demonstrated by selective left carotid injection. The flow from the right carotid dissipated itself entirely into the cavernous sinus fistula. Superselective right external and internal carotid arteriograms failed to show any other arteriovenous communications. Late phase roentgenograms demonstrated massive flow from the cavernous sinus into the ophthalmic vein and into the angular vein.

In view of the demonstrated large size of the arteriovenous communication, it was elected to attempt control of the arteriovenous fistula by embolization with muscle fragments.

A right frontotemporal craniotomy was performed. A Heifetz clip was placed across the carotid artery just distal to the take-off of the opthalmic artery. An arteriotomy was performed on the right internal carotid artery and six fragments of muscle obtained from the sternocleido-mastoid, tagged with metallic clips, were introduced as emboli. Subsequent arteriograms demonstrated satisfactory occlusion of the fistula.

In spite of the apparent success of the operative procedure, roaring in the right ear increased over the ensuing three months, as did the hearing loss. This was attributed to discontinuity of ossicular change secondary to the trauma.

Discussion

The management of intracranial arteriovenous fistulae has been revolutionized in the recent past with perfection of "guided embolization." Superselective introduction of infarct particles for obliteration of arteriovenous fistulae has been recommended in literature. Because of the siphoning effect of such an arterio-

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venous fistula, a predilection of flow to the arteriovenous fistula exists, facilitating placement of the infarct particles. In addition to that, guidance of metallic infarct particles by a powerful external magnet has been suggested. The infarct particles have also been connected to fine nylon strings permitting retrieval of a given infarct pellet that might fortuitously infarct a vessel or area not intended for occlusion.

Management of carotid-cavernous sinus fistulae can also utilize the time-honored procedure of double ligation of the carotid artery above and below the fistula, if adequate collateral supply to the affected hemisphere can be demonstrated.

Placement of an occlusive clip above the arteriovenous fistula and embolization of the arteriovenous fistula with muscle particles may likewise be deployed for successful management of this lesion as was done in our patient. Demonstration of adequate collateral supply via the anterior or posterior communicator to the affected hemisphere prior to surgical intervention is a prerequisite.◀



FIGURE 2

AN OPERATIVE carotid arteriogram demonstrates embolization of the carotid-cavernous sinus fistula by multiple muscle fibers marked with silver clips for identification. The arteriogram demonstrates almost complete occlusion of the fistula and a marked decrease of flow into the ophthalmic vein. Several more infarct patricles were placed to completely occlude the fistula.

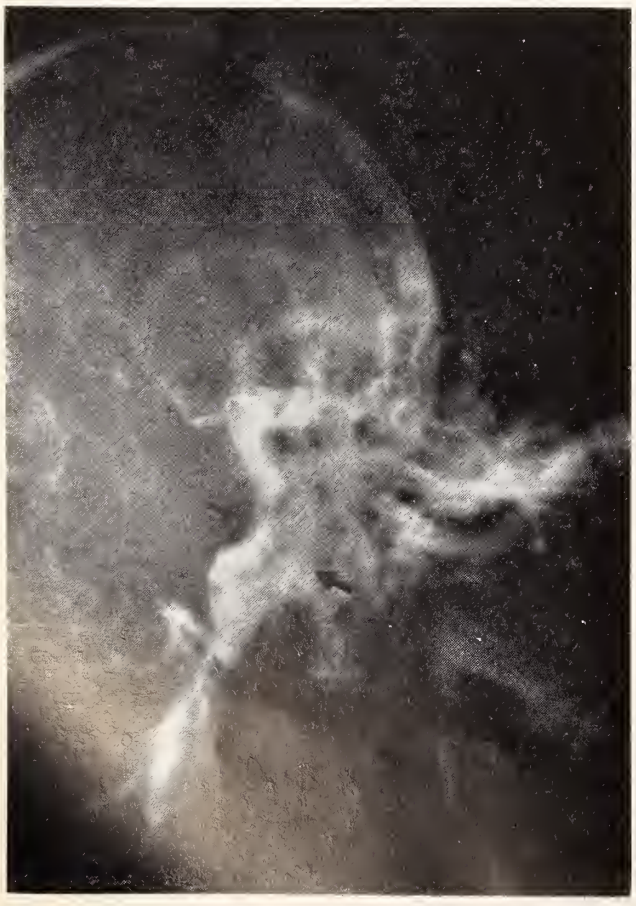


FIGURE 1

AN EARLY PHASE right carotid arteriogram demonstrates massive opacification of the cavernous sinus with flow into the ophthalmic and angular veins. Note the siphoning effect of the arteriovenous fistula with resulting lack of flow into the hemisphere normally supplied by this carotid system.

Mycoplasmal Pneumonia

R. RUSSELL MARTIN, M.D.
Indianapolis*

CLINICIANS have recognized for many decades that a large proportion of the pneumonias occurring in children and young adults are not caused by pneumococcus or other bacteria. Because the syndrome of acute non-bacterial pneumonia can be distinguished by clinical criteria from the bacterial pneumonias, this form of pulmonary infection has been called "primary atypical pneumonia."

A wide variety of micro-organisms has been found to cause these infections, including a number of viruses (e.g., adenoviruses, respiratory syncytial, parainfluenza), rickettsia-like organisms (psittacosis, Q fever), and mycoplasma. It is usually not important for the physician to establish the etiology of a viral pneumonia, since treatment is symptomatic and the infection is self-limiting. The course of psittacosis, Q fever or mycoplasmal pneumonia can be modified by antibiotic therapy, so there is justification for trying to distinguish these infections from those caused by viruses. Because of the frequency with which mycoplasma infection is encountered, this discussion will emphasize the features of this illness.

Clinical Picture

The clinical features of primary atypical pneumonia due to *Mycoplasma pneumoniae* have been elucidated by volunteer studies in which antibody-free subjects have been inoculated with the organism. The resulting illness is very similar to the naturally occurring disease. In experimental *M. pneumoniae* disease, there is a prodromal illness of one to three days of upper respiratory symptoms followed by pneumonia at 9 to 12 days after inoculation. A small amount of thick sputum is usually produced. Stained slides of the sputum may show numerous polymorphonuclear cells but few or no bacteria. Physical findings vary from patient to patient, but the physical findings of pneumonia are often minimal or absent even when the chest x-ray definitely reveals pneumonia. Some chest discomfort may occur but pleural involvement is absent. Fever is commonly present for about five days, with general clinical improvement occurring after fever disappears. In volunteers inoculated with mylcoplasma, there has been a frequent occurrence of bullous myringitis. This feature has not been recognized very often in spontaneously occurring disease.

Mycoplasma pneumoniae is a very common cause of primary atypical pneumonia in young adults. Especially among college students and military recruits, there may be outbreaks affecting a large proportion of the susceptible population. Mycoplasmal pneumonia is rare in preschool or elementary-school children. Pneumonia in the younger children is usually viral.

Laboratory

The agent that causes mycoplasmal pneumonia was thought for many years to be a virus. However, for almost 10 years it has been known that the micro-organism is a member of the genus mycoplasma, which are the smallest of free-living organisms. These microbes lack a rigid cell wall, but they are surrounded by a triple-layered membrane. They are not damaged by cell-wall active antibiotics, such as the penicillins. These organisms do not grow in conventional laboratory media, and only specialized laboratories can successfully isolate *M. pneumoniae* on culture. Other tests are required to support the diagnosis of mycoplasmal pneumonia.

About one-half of the cases of primary atypical pneumoniae are associated with elevated cold-agglutinin antibodies in the serum. A cross-reacting antibody against Streptococcus MG is present less often. The specific diagnosis may be made by documenting a four-fold or greater increase in complement-fixing, neutralizing or fluorescent antibodies in comparisons between acute and convalescent sera. Serological studies for the common causes of primary atypical pneumonia are available through the State Board of Health laboratories.

Therapy

One reason for distinguishing mycoplasmal pneumonia from other infections is that the course of the

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disease may be shortened by antibiotic therapy. The pulmonary infection due to *M. pneumoniae* is almost never fatal, but there can be significant morbidity due to the infection, with prolonged cough up to two or three weeks after recovery. If the patient with mycoplasmal pneumonia is seen in the first three days of illness, he may be treated with either a tetracycline or erythromycin with probable benefit. If the patient is seen after about three days, antibiotics probably will not alter the course.

Even treated patients continue to have mycoplasma cultureable from the sputum and throat for several weeks after complete clinical recovery has occurred.

Prevention

An effective vaccine against *M. pneumoniae* has been developed, but the limited significance of this illness outside the college student and military populations restricts its usefulness to these specialized populations.

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Errata

Photographs of Drs. M. O. Scamahorn and Peter R. Petrich that appeared on page 1029 of the Convention Section of the September *Journal* were transposed.

The legends under the two photographs on page 1183 of the October *Journal* illustrating the article by Doctors Burnikel and Heinrich were transposed.

The *Journal* apologizes to those concerned and regrets any inconvenience or embarrassment caused by these errors.

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Guest Editorial

Peer Review

Editor's Note: The following is a reprint from the February 1970 *California Medicine*. It was written by Alf T. Haerem, M.D., Redwood City, California. We are indebted to *California Medicine* for permission to reprint this letter.

To the Editor: "Peer Review" has been a favorite phrase that recurs in the emanations from various echelons of organized medicine and seems to be highly touted as a remedy for a number of ills that beset medical practice. Like many popular remedies, however, the original bloom of the manufacturer's enthusiasm is eventually dimmed somewhat with the reporting of undesirable side reactions. From what I read, it seems to me that the peer review enthusiasts haven't been reading the package inserts.

I recently had the opportunity to observe the operation of the peer review concept in the form of an inspection of the hospital where I have been practicing for almost twenty years by none less than the Joint Commission on Accreditation. If this is peer review at its best and will cure what's wrong the patient, I regret to report that it also causes more than a modicum of trauma, tenesmus and tetany in the process. Although this is only a preliminary report to your readers, perhaps some of them have made similar observations and hopefully it may prompt further investigation by suitable committees of CMA.

The paper tiger that inspected us seemed convinced that the only good doctor is a literary one and that a voluminous history full of minutiae guarantees the excellence of the attending physician. That such a notion is patently false must be apparent to anyone who actually handles patients. This obsessive neurosis regarding charts becomes manifest every time their inspector appears and the last such display of papyrophilia was a temper tantrum about family histories in our charts. Surely, until some genius reports on the genetic implications of hemorrhoids, couldn't we leave it up to the attending physician as to whether such data should be included? Yet, the Commission is adamant and I know of major league umpires that have less rigid concepts than the Commission.

Our general practice section was especially affected by the "cure." Their own meetings, which were not evaluated, were summarily dismissed as being inadequate "for credit." They can only acquire learning in another section, according to the Commission's edict, apparently on the old theory that the only way to feed sparrows is by feeding horses. Now, the generalist can listen to a lecture in the surgical section meeting and "get credit" while if the same surgeon gives the same lecture in the same room at a GP meeting, it doesn't count. This denigration of the generalist comes at a time when there seems to be a general acceptance of his importance as a family doctor in American medicine.

Another ultimatum affecting our practice is the development of a structure of profiles on each doctor which will supposedly prevent a physician from attempting unfamiliar procedures. The delicate matter of privileges had already been worked out by our staff but that system was scrapped by the Commission without evaluation. Any attempt at originality or innovation that doesn't comply is apparently squelched from the infallible Olympian Heights in Chicago.

All this might have been good-naturedly tolerated but since Medicare, hospital payments will be denied unless the hospital has Commission approval. With such newly acquired puissance, the Commission's suggestions become edicts and their opinions ultimatums. Taxpayer patients who built our hospital may be denied the benefits of Medicare because of the capricious decisions of a Commission that has no insights into the medical needs of the community. This seems to be very close to the "restraint of trade problem" that plagued the AMA in the thirties and at any rate appropriate legal countermeasures can reasonably be expected any day.

No one doubts the motives of the Commission and it would seem that our staff should enjoy a reciprocal opinion from the Commission. Instead, the Commission seems to fear and distrust doctors generally. Perhaps this iatrophobia is more apparent than real. Perhaps we just drew a catankerous inspector whose jaundiced and crapulous mien doesn't reflect the attitude of the Commission. However, the fatuous nitpicking, niggling, cavilling and inane regulations have served to increase the secretarial burden of the hospital, interfere with the care of patients and add to skyrocketing costs. One wonders at the response that this fiasco would have evoked, if it were enacted by a government agency. As it is, it has hardly improved professional solidarity and the term "peer review" has acquired new unsavory connotations to many members of our staff. Is this operation the will of doctors generally? How long will these buffoons continue to abuse our patience?

Several years ago, a wag in our County Medical Society, calling himself Phil O. Sofer, Jr., wrote a verse about all this which I repeat below. Maybe peer review will take its real place in our therapeutic armamentarium when we all appreicate its virtues *and* dangers.

Alf T. Haerem, M.D.

THE ODD AUDIT BIRD

(Tune: Tit Willow)

On a spreading Sequoia, an audit bird lit
Singing, "Audit! I'll Audit! I'll Audit!"
And I said, "Little Audit Bird, why do you sit
Singing 'Audit, I'll Audit, I'll Audit!'"
"Is it iatrophobia, Birdie?" I cried,
"Or a drive for reform in your little inside?"
"Oh, my motives are purer than snow!" he replied,
Adding, "Audit, I'll Audit, I'll Audit!"
For this virtuous bird with the scholary plume,
Singing, "Audit! I'll Audit! I'll Audit!"
Was convinced that all others should sing the same tune
And sing, "Audit, I'll Audit, I'll Audit!"
Messianic in fervor, he brooked no revolt;
For the bird with less plume was considered a dolt,
Whom he thought he could show how to sing and to moult
With his "Audit! I'll Audit! I'll Audit!"
Now the song and the plume are ordained at the hatch;
Not by "Audit, I'll Audit! I'll Audit!"
And you only can change it by starting from scratch,
Not by "Audit! I'll Audit! I'll Audit!"
For the value of song will be hard to assess
By the meager criteria you may possess,
Maybe singing together might be a success —
Without "Audit! I'll Audit! I'll Audit!" ◄

Editorial Notes . . .

British physicians and dentists are troubled and angry because of the government offer of salary increases. A review committee studied the situation for two years and recommended an immediate 30% increase to the Wilson administration. This produced a 15% raise. Reconsideration of the committee's recommendations has now produced an additional 5% increase, far enough from what was regarded as the smallest increase that would be fair to promote widespread dissatisfaction. The British Dental Association is said to have reacted in anger; the British Medical Association "adopted a cautious, lukewarm attitude."

The first examination conducted by the American Board of Family Practice was written by 2078 physicians. A large majority (81.6%) of them passed successfully. Of those who graduated within the past twenty years, 95.5% passed. The second examination will be held in February 1971. All those who pass the first two examinations will be included in the charter membership group.

The fact that the mouth does not approximate body temperature until after it has been closed for a minute and preferably two minutes is not appreciated by those who invent fast-reading electronic thermometers. Diagnostic I, a new hand-held electronic thermometer, is said to give an accurate reading in five seconds. Accurate, no doubt, but several degrees below body temperature unless the mouth has been closed on the thermometer for much longer. Diagnostic I is also fitted with a rectal probe. This method should be more indicative of body temperature as determined by a quick reading since the rectal confines are, presumably, not cooled by outside air. ◄

Certain systematic methods of scientific thinking may produce much more rapid progress than others.

STRONG INFERENCE*

JOHN R. PLATT
*Chicago, Ill.***

SCIENTISTS these days tend to keep up a polite fiction that all science is equal. Except for the work of the misguided opponent whose arguments we happen to be refuting at the time, we speak as though every scientist's field and methods of study are as good as every other scientist's, and perhaps a little better. This keeps us all cordial when it comes to recommending each other for government grants.

But I think anyone who looks at the matter closely will agree that some fields of science are moving forward very much faster than others, perhaps by an order of magnitude, if numbers could be put on such estimates. The discoveries leap from the headlines—and they are real advances in complex and difficult subjects, like molecular biology and high-energy physics. As Alvin Weinberg says (*1*), "Hardly a month goes by without a stunning success in molecular biology being reported in the Proceedings of the National Academy of Sciences."

Why should there be such rapid advances in some fields and not in others? I think the usual explanations that we tend to think of—such as the tractability of the subject, or the quality or education of the men drawn into it, or the size of research contracts—are important but inadequate. I have begun to believe that the primary factor in scientific advance is an intellectual one. These rapidly moving fields are fields where a particular method of doing scientific research is systematically used and taught, an accumulative method of inductive inference that is so effective that I think it should be given the name of "strong inference." I believe it is important to examine this method, its use and history and rationale, and to see whether other groups and individuals might learn to adopt it profitably in their own scientific and intellectual work.

In its separate elements, strong inference is just the simple and old-fashioned method of inductive inference that goes back to Francis Bacon. The steps are familiar to every college student and are practiced, off and on, by every scientist. The difference comes in their systematic application. Strong inference consists of applying the following steps to every problem in science, formally and explicitly and regularly:

1) Devising alternative hypotheses;

2) Devising a crucial experiment (or several of them), with alternative possible outcomes, each of which will, as nearly as possible, exclude one or more of the hypotheses;

3) Carrying out the experiment so as to get a clean result;

1′) Recycling the procedure, making subhypotheses or sequential hypotheses to refine the possibilities that remain; and so on.

It is like climbing a tree. At the first fork, we choose—or, in this case, "nature" or the experimental outcome chooses—to go to the right branch or the left; at the next fork, to go left or right; and so on. There are similar branch points in a "conditional computer program," where the next move depends on the result of the last calculation. And there is a "conditional inductive tree" or "logical tree" of this kind written out in detail in many first-year chemistry books, in the table of steps for qualitative analysis of an unknown sample, where the student is led through a real problem of consecutive inference: Add reagent A; if you get a red precipitate, it is subgroup alpha and you filter and add reagent B; if not, you add the other reagent, B′; and so on.

On any new problem, of course, inductive inference is not as simple and certain as deduction, because it involves reaching out into the un-

* Reprinted from *Science*, Vol. 146, pp. 347-353, 16 October 1964. Copyright 1964 by the American Association for the Advancement of Science. This is the text of an address given before the Division of Physical Chemistry of the American Chemical Society in September, 1963, under the title "The New Baconians."

** Professor of biophysics and physics at the University of Chicago, Chicago, Ill.

known. Steps 1 and 2 require intellectual inventions, which must be cleverly chosen so that hypothesis, experiment, outcome, and exclusion will be related in a rigorous syllogism; and the question of how to generate such inventions is one which has been extensively discussed elsewhere (*2, 3*). What the formal schema reminds us to do is to try to make these inventions, to take the next step, to proceed to the next fork, without dawdling or getting tied up in irrelevancies.

It is clear why this makes for rapid and powerful progress. For exploring the unknown, there is no faster method; this is the minimum sequence of steps. Any conclusion that is not an exclusion is insecure and must be rechecked. Any delay in recycling to the next set of hypotheses is only a delay. Strong inference, and the logical tree it generates, are to inductive reasoning what the syllogism is to deductive reasoning, in that it offers a regular method for reaching firm inductive conclusions one after the other as rapidly as possible.

"But what is so novel about this?" someone will say. This is *the* method of science and always has been; why give it a special name? The reason is that many of us have almost forgotten it. Science is now an everyday business. Equipment, calculations, lectures become ends in themselves. How many of us write down our alternatives and crucial experiments every day, focusing on the *exclusion* of a hypothesis? We may write our scientific papers so that it looks as if we had steps 1, 2, and 3 in mind all along. But in between, we do busywork. We become "method-oriented" rather than "problem-oriented." We say we prefer to "feel our way" toward generalizations. We fail to teach our students how to sharpen up their inductive inferences. And we do not realize the added power that the regular and explicit use of alternative hypotheses and sharp exclusions could give us at every step of our research.

The difference between the average scientist's informal methods and the methods of the strong-inference users is somewhat like the difference between a gasoline engine that fires occasionally and one that fires in steady sequence. If our motorboat engines were as erratic as our deliberate intellectual efforts, most of us would not get home for supper.

Molecular Biology

The new molecular biology is a field where I think this systematic method of inference has become wide-spread and effective. It is a complex field; yet a sucession of crucial experiments over the past decade has given us a surprisingly detailed understanding of hereditary mechanisms and the control of enzyme formation and protein synthesis.

The logical structure shows in every experiment. In 1953 James Watson and Francis Crick proposed that the DNA molecule—the "hereditary substance" in a cell—is a long two-stranded helical molecule (*4*). This suggested a number of alternatives for crucial test. Do the two strands of the helix stay together when a cell divides, or do they separate? Matthew Meselson and Franklin Stahl used an ingenious isotope-density-labeling technique which showed that they separate (*5*). Does the DNA helix always have two strands, or can it have three, as atomic models suggest? Alexander Rich showed it can have either, depending on the ionic concentration (*6*). These are the kinds of experiments John Dalton would have liked, where the combining entities are not atoms but long macromolecular strands.

Or take a different sort of question: Is the "genetic map"—showing the statistical relationship of different genetic characteristics in recombination experiments—a one-dimensional map like the DNA molecule (that is, a linear map), as T. H. Morgan proposed in 1911, or does it have two-dimensional loops or branches? Seymour Benzer showed that his hundreds of fine microgenetic experiments on bacteria would fit only the mathematical matrix for the one-dimensional case (*7*).

But of course, selected crucial experiments of this kind can be found in every field. The real difference in molecular biology is that formal inductive inference is so systematically practiced and taught. On any given morning at the Laboratory of Molecular Biology in Cambridge, England, the blackboards of Francis Crick or Sidney Brenner will commonly be found covered with logical trees. On the top line will be the hot new result just up from the laboratory or just in by letter or rumor. On the next line will be two or three alternative explanations, or a little list of "What he did wrong." Underneath will be a series of suggested experiments or controls that can reduce the number of possibilities. And so on. The tree grows during the day as one man or another comes in and argues about why one of the experiments wouldn't work, or how it should be changed.

The strong-inference attitude is evident just in the style and language in which the papers are written. For example, in analyzing theories of antibody formation, Joshua Lederberg (*8*) gives a list of nine propositions "subject to denial," discussing which ones would be "most vulnerable to experimental test."

The papers of the French leaders Francois Jacob and Jacques Monod are also celebrated for their high "logical density," with paragraph after paragraph of linked "inductive syllogisms." But the style is widespread. Start with the first paper in the *Journal of Molecular Biology* for 1964 (*9*), and you immediately find: "Our conclusions . . . might be in-

valid if . . . (i) . . . (ii) . . . or (iii) . . . . We shall describe experiments which eliminate these alternatives." The average physicist or chemist or scientist in any field accustomed to less closely reasoned articles and less sharply stated inferences will find it a salutary experience to dip into that journal almost at random.

Resistance to Analytical Methodology

This analytical approach to biology has sometimes become almost a crusade, because it arouses so much resistance in many scientists who have grown up in a more relaxed and diffuse tradition. At the 1958 Conference on Biophysics, at Boulder, there was a dramatic confrontation between the two points of view. Leo Szilard said: "The problems of how enzymes are induced, of how proteins are synthesized, of how antibodies are formed, are closer to solution than is generally believed. If you do stupid experiments, and finish one a year, it can take 50 years. But if you stop doing experiments for a little while and *think* how proteins can possibly be synthesized, there are only about 5 different ways, not 50! And it will take only a few experiments to distinguish these."

One of the young men added: "It is essentially the old question: How *small* and *elegant* an experiment can you perform?"

These comments upset a number of those present. An electron microscopist said, "Gentlemen, this is off the track. This is philosophy of science."

Szilard retorted, "I was not quarreling with third-rate scientists: I was quarreling with first-rate scientists."

A physical chemist hurriedly asked, "Are we going to take the official photograph before lunch or after lunch?"

But this did not deflect the dispute. A distinguished cell biologist rose and said, "No two cells give the same properties. Biology is the science of heterogeneous systems." And he added privately, "You know there are *scientists;* and there are people in science who are just working with these over-simplified model systems—DNA chains and in vitro systems—who are not doing science at all. We need their auxiliary work: they build apparatus, they make minor studies, but they are not scientists."

To which Cy Levinthal replied: "Well, there are two kinds of biologists, those who are looking to see if there is one thing that can be understood, and those who keep saying it is very complicated and that nothing can be understood. . . . You must study the *simplest* system you think has the properties you are interested in."

As they were leaving the meeting, one man could be heard muttering, "What does Szilard expect me to do —shoot myself?"

Any criticism or challenge to consider changing our methods strikes, of course, at all our ego-defenses. But in this case the analytical method offers the possibility of such great increases in effectiveness that it is unfortunate that it cannot be regarded more often as a challenge to learning rather than as a challenge to combat. Many of the recent triumphs in molecular biology have in fact been achieved on just such "over-simplified model systems," very much along the analytical lines laid down in the 1958 discussion. They have not fallen to the kind of men who justify themselves by saying, "No two cells are alike," regardless of how true that may ultimately be. The triumphs are in fact triumphs of a new way of thinking.

High-Energy Physics

This analytical thinking is rare, but it is by no means restricted to the new biology. High-energy physics is another field where the logic of exclusions is obvious, even in the newspaper accounts. For example, in the famous discovery of C. N. Yang and T. D. Lee, the question that was asked was: Do the fundamental particles conserve mirror-symmetry or parity" in certain reactions, or do they not? The crucial experiments were suggested; within a few months they were done, and conservation of parity was found to be excluded. Richard Garwin, Leon Lederman, and Marcel Weinrich did one of the crucial experiments. It was thought of one evening at suppertime; by midnight they had rearranged the apparatus for it; and by 4 a.m. they had picked up the predicted pulses showing the non-conservation of parity (*10*). The phenomena had just been waiting, so to speak, for the explicit formulation of the alternative hypotheses.

The theorists in this field take pride in trying to predict new properties or new particles explicitly enough so that if they are not found the theories will fall. As the biologist W. A. H. Rushton has said (*11*), "A theory which cannot be mortally endangered cannot be alive." Murray Gell-Mann and Yuval Ne'eman recently used the particle grouping which they call "The Eightfold Way" to predict a missing particle, the Omega-Minus, which was then looked for and found (*12*). But one alternative branch of the theory would predict a particle with one-third the usual electronic charge, and it was not found in the experiments, so this branch must be rejected.

The logical tree is so much a part of high-energy physics that some stages of it are commonly built, in fact, into the electronic coincidence circuits that detect the particles and trigger the bubble-chamber photographs. Each kind of particle should give a different kind of pattern in the electronic counters, and the circuits can be set to exclude or include whatever types of events are desired. If the distinguishing criteria are sequential, they may even run through a complete logical tree in a

microsecond or so. This electronic preliminary analysis, like human preliminary analysis of alternative outcomes, speeds up progress by sharpening the criteria. It eliminates hundreds of thousands of the irrelevant pictures that formerly had to be scanned, and when it is carried to its limit, a few output pulses, hours apart, may be enough to signal the existence of the antiproton or the fall of a theory.

I think the emphasis on strong inference in the two fields I have mentioned has been partly the result of personal leadership, such as that of the classical geneticists in molecular biology, or of Szilard with his "Midwest Chowder and Bacteria Society" at Chicago in 1948-50, or of Max Delbruck with his summer courses in phage genetics at Cold Spring Harbor. But it is also partly due to the nature of the fields themselves. Biology, with its vast informational detail and complexity, is a "high-information" field, where years and decades can easily be wasted on the usual type of "low-information" observation or experiments if one does not think carefully in advance about what the most important and conclusive experiments would be. And in high-energy physics, both the "information flux" of particles from the new accelerators and the million-dollar costs of operation have forced a similar analytical approach. It pays to have a top-notch group debate every experiment ahead of time; and the habit spreads throughout the field.

Induction and Multiple Hypotheses

Historically, I think, there have been two main contributions to the development of a satisfactory strong-inference method. The first is that of Francis Bacon (*13*). He wanted a "surer method" of "finding out nature" than either the logic-chopping or all-inclusive theories of the time or the laudable but crude attempts to make inductions "by simple enumeration." He did not merely urge experiments, as some suppose; he showed the fruitfulness of interconnecting theory and experiment so that the one checked the other. Of the many inductive procedures he suggested, the most important, I think, was the conditional inductive tree, which proceeded from alternative hypotheses (possible "causes," as he calls them), through crucial experiments ("Instances of the Fingerpost"), to exclusion of some alternatives and adoption of what is left ("establishing axioms"). His Instances of the Fingerpost are explicitly at the forks in the logical tree, the term being borrowed "from the fingerposts which are set up where roads part, to indicate the several directions."

Many of his crucial experiments proposed in Book II of *The New Organon* are still fascinating. For example, in order to decide whether the weight of a body is due to its "inherent nature," as some had said, or is due to the attraction of the earth, which would decrease with distance, he proposes comparing the rate of a pendulum clock and a spring clock and then lifting them from the earth to the top of a tall steeple. He concludes that if the pendulum clock on the steeple "goes more slowly than it did on account of the diminished virtue of its weight . . . we may take the attraction of the mass of the earth as the cause of weight."

Here was a method that could separate off the empty theories!

Bacon said the inductive method could be learned by anybody, just like learning to "draw a straighter line or more perfect circle . . . with the help of a ruler or a pair of compasses." "My way of discovering sciences goes far to level men's wit and leaves but little to individual excellence, because it performs everything by the surest rules and demonstrations." Even occasional mistakes would not be fatal. "Truth will sooner come out from error than from confusion."

It is easy to see why young minds leaped to try it.

Nevertheless there is a difficulty with this method. As Bacon emphasizes, it is necessary to make "exclusions." He says: "The induction which is to be available for the discovery and demonstration of sciences and arts must analyze nature by proper rejections and exclusions; and then, after a sufficient number of negatives, come to a conclusion on the affirmative instances." "[To man] it is granted only to proceed at first by negatives, and at last to end in affirmatives after exclusion has been exhausted."

Or, as the philosopher Karl Popper says today, there is no such thing as proof in science—because some later alternative explanation may be as good or better—so that science advances only by disproofs. There is no point in making hypotheses that are not falsifiable, because such hypotheses do not say anything; "it must be possible for an empirical scientific system to be refuted by experience" (*14*).

The difficulty is that disproof is a hard doctrine. If you have a hypothesis and I have another hypothesis, evidently one of them must be eliminated. The scientist seems to have no choice but to be either soft-headed or disputatious. Perhaps this is why so many tend to resist the strong analytical approach—and why some great scientists are so disputatious.

Fortunately, it seems to me, this difficulty can be removed by the use of a second great intellectual invention, the "method of multiple hypotheses," which is what was needed to round out the Baconian scheme. This is a method that was put forward by T. C. Chamberlin (*15*), a geologist at Chicago at the turn of the century, who is best known for his contribution to the Chamberlin-Moulton hypothesis of the origin of the solar system.

Chamberlin says our trouble is that when we make a single hypothesis, we become attached to it.

"The moment one has offered an original explanation for a phenomenon which seems satisfactory, that moment affection for his intellectual child springs into existence, and as the explanation grows into a definite theory his parental affections cluster about his offspring and it grows more and more dear to him. . . . There springs up also unwittingly a pressing of the theory to make it fit the facts and a pressing of the facts to make them fit the theory. . . .

"To avoid this grave danger, the method of multiple working hypotheses is urged. It differs from the simple working hypothesis in that it distributes the effort and divides the affections. . . . Each hypothesis suggests its own criteria, its own means of proof, its own method of developing the truth, and if a group of hypotheses encompass the subject on all sides, the total outcome of means and of methods is full and rich."

Chamberlin thinks the method "leads to certain distinctive habits of mind" and is of prime value in education. "When faithfully followed for a sufficient time, it develops a mode of thought of its own kind which may be designated the habit of complex thought. . . ."

This charming paper deserves to be reprinted in some more accessible journal today, where it could be required reading for every graduate student—and for every professor.

It seems to me that Chamberlin has hit on the explanation—and the cure—for many of our problems in the sciences. The conflict and exclusion of alternatives that is necessary to sharp inductive inference has been all too often a conflict between men, each with his single Ruling Theory. But whenever each man begins to have multiple working hypotheses, it becomes purely a conflict between ideas. It becomes much easier then for each of us to aim every day at conclusive disproofs—at *strong* inference—without either reluctance or combativeness. In fact, when there are multiple hypotheses which are not anyone's "personal property" and when there are crucial experiments to test them, the daily life in the laboratory takes on an interest and excitement it never had, and the students can hardly wait to get to work to see how the detective story will come out. It seems to me that this is the reason for the development of those "distinctive habits of mind" and the "complex thought" that Chamberlin described, the reason for the sharpness, the excitement, the zeal, the teamwork—yes, even international teamwork—in molecular biology and high-energy physics today. What else could be so effective?

When multiple hypotheses become coupled to strong inference, the scientific search becomes an emotional powerhouse as well as an intellectual one.

Unfortunately, I think, there are other areas of science today that are sick by comparison, because they have forgotten the necessity for alternative hypotheses and disproof. Each man has only one branch—or none—on the logical tree, and it twists at random without ever coming to the need for a crucial decision at any point. We can see from the external symptoms that there is something scientifically wrong. The Frozen Method. The Eternal Surveyor. The Never Finished. The Great Man With a Single Hypothesis. The Little Club of Dependents. The Vendetta. The All-Encompassing Theory Which Can Never Be Falsified.

Some cynics tell a story, which may be apocryphal, about the theoretical chemist who explained to his class,

"And thus we see that the C-Cl bond is longer in the first compound than in the second because the percent of ionic character is smaller."

A voice from the back of the room said, "But Professor X, according to the Table, the C-Cl bond is shorter in the first compound."

"Oh, is it?" said the professor. "Well, that's still easy to understand, because the double-bond character is higher in that compound."

To the extent that this kind of story is accurate, a "theory" of this sort is not a theory at all, because it does not exclude anything. It predicts everything, and therefore does not predict anything. It becomes simply a verbal formula which the graduate student repeats and believes because the professor has said it so often. This is not science, but faith; not theory, but theology. Whether it is hand-waving or number-waving or equation-waving, a theory is not a theory unless it can be disproved. That is, unless it can be falsified by some possible experimental outcome.

In chemistry, the resonance theorists will of course suppose that I am criticizing *them*, while the molecular-orbital theorists will suppose I am criticizing *them*. But their actions, for I include myself among them—speak for themselves. A failure to agree for 30 years is public advertisement of a failure to disprove.

My purpose here, however, is not to call names but rather to say that we are all sinners, and that in every field and in every laboratory we need to try to formulate multiple alternative hypotheses sharp enough to be capable of disproof.

Systematic Application

I think the work methods of a number of scientists have been testimony to the power of strong inference. Is success not due in many cases to systematic use of Bacon's "surest rules and demonstrations" as much as to rare and unattainable intellectual power? Faraday's famous diary (*16*), or Fermi's notebooks (*3*, *17*), show how these men believed in the effectiveness of daily steps in applying formal inductive

methods to one problem after another.

Within 8 weeks after the discovery of x-rays, Roentgen had identified 17 of their major properties. Every student should read his first paper (*18*). Each demonstration in it is a little jewel of inductive inference. How else could the proofs have gone so fast, except by a method of maximum effectiveness?

Organic chemistry has been the spiritual home of strong inference from the beginning. Do the bonds alternate in benzene or are they equivalent? If the first, there should be five disubstituted derivatives; if the second, three. And three it is (*19*). This is a *strong*-inference test —not a matter of measurement, of whether there are grams or milligrams of the products, but a matter of logical alternatives. How else could the tetrahedral carbon atom or the hexagonal symmetry of benzene have been inferred 50 years before the inferences could be confirmed by x-ray and infrared measurement?

We realize that it was out of this kind of atmosphere that Pasteur came to the field of biology. Can anyone doubt that he brought with him a completely different method of reasoning? Every 2 or 3 years he moved to one biological problem after another, from optical activity to the fermentation of beet sugar, to the "diseases" of wine and beer, to the disease of silkworms, to the problem of "spontaneous generation," to the anthrax disease of sheep, to rabies. In each of these fields there were experts in Europe who knew a hundred times as much as Pasteur, yet each time he solved problems in a few months that they had not been able to solve. Obviously it was not encyclopedic knowledge that produced his success, and obviously it was not simply luck, when it was repeated over and over again; it can only have been the systematic power of a special method of exploration. Are bacteria falling in? Make the necks of the flasks S-shaped. Are bacteria sucked in by the partial vacuum? Put in a cotton plug. Week after week his crucial experiments build up the logical tree of exclusions. The drama of strong inference in molecular biology today is only a repetition of Pasteur's story.

The grand scientific syntheses, like those of Newton and Maxwell, are rare and individual achievements that stand outside any rule or method. Nevertheless it is interesting to note that several of the great synthesizers have also shown the strong-inference habit of thought in their other work, as Newton did in the inductive proofs of his *Opticks* and Maxwell did in his experimental proof that three and only three colors are needed in color vision.

A Yardstick of Effectiveness

I think the evident effectiveness of the systematic use of strong inference suddenly gives us a yardstick for thinking about the effectiveness of scientific methods in general. Surveys, taxonomy, design of equipment, systematic measurements and tables, theoretical computations—all have their proper and honored place, provided they are parts of a chain of precise induction of how nature works. Unfortunately, all too often they become ends in themselves, mere time-serving from the point of view of real scientific advance, a hypertrophied methodology that justifies itself as a lore of respectability.

We praise the "lifetime of study," but in dozens of cases, in every field, what was needed was not a lifetime but rather a few short months or weeks of analytical inductive inference. In any new area we should try, like Roentgen, to see how fast we can pass from the general survey to analytical inferences. We should try, like Pasteur, to see whether we can reach strong inferences that encyclopedism could not discern.

We speak piously of taking measurements and making small studies that will "add another brick to the temple of science." Most such bricks just lie around the brickyard (*20*). Tables of constants have their place and value, but the study of one spectrum after another, if not frequently re-evaluated, may become a substitute for thinking, a sad waste of intelligence in a research laboratory, and a mistraining whose crippling effects may last a lifetime.

To paraphrase an old saying, Beware of the man of one method or one instrument, either experimental or theoretical. He tends to become method-oriented rather than problem-oriented. The method-oriented man is shackled; the problem-oriented man is at least reaching freely toward what is most important. Strong inference redirects a man to problem-orientation, but it requires him to be willing repeatedly to put aside his last methods and teach himself new ones.

On the other hand, I think that anyone who asks the question about scientific effectiveness will also conclude that much of the mathematicizing in physics and chemistry today is irrelevant if not misleading.

The great value of mathematical formulation is that when an experiment agrees with a calculation to five decimal places, a great many alternative hypotheses are pretty well excluded (though the Bohr theory and the Schrodinger theory both predict exactly the same Rydberg constant!). But when the fit is only to two decimal places, or one, it may be a trap for the unwary; it may be no better than any rule-of-thumb extrapolation, and some other kind of qualitative exclusion might be more rigorous for testing the assumptions and more important to scientific understanding than the quantitative fit.

I know that this is like saying that the emperor has no clothes. Today we preach that science is not science unless it is quantitative. We substitute correlations for causal studies, and physical equations for organic reasoning. Measurements and equations

are supposed to sharpen thinking, but, in my observation, they more often tend to make the thinking noncausal and fuzzy. They tend to become the object of scientific manipulation instead of auxiliary tests of crucial inferences.

Many—perhaps most—of the great issues of science are qualitative, not quantitative, even in physics and chemistry. Equations and measurements are useful when and only when they are related to proof; but proof or disproof comes first and is in fact strongest when it is absolutely convincing without any quantitative measurement.

Or to say it another way, you can catch phenomena in a logical box or in a mathematical box. The logical box is coarse but strong. The mathematical box is fine-grained but flimsy. The mathematical box is a beautiful way of wrapping up a problem, but it will not hold the phenomena unless they have been caught in a logical box to begin with.

What I am saying is that, in numerous areas that we call science, we have come to like our habitual ways, and our studies that can be continued indefinitely. We measure, we define, we compute, we analyze, but we do not exclude. And this is not the way to use our minds most effectively or to make the fastest progress in solving scientific questions.

Of course it is easy—and all too common—for one scientist to call the others unscientific. My point is not that my particular conclusions here are necessarily correct, but that we have long needed some absolute standard of possible scientific effectiveness by which to measure how well we are succeeding in various areas—a standard that many could agree on and one that would be undistorted by the scientific pressures and fashions of the times and the vested interests and busywork that they develop. It is not public evaluation I am interested in so much as a private measure by which to compare one's own scientific performance with what it might be. I believe that strong inference provides this kind of standard of what the maximum possible scientific effectiveness could be—as well as a recipe for reaching it.

Aids to Strong Inference

How can we learn the method and teach it? It is not difficult. The most important thing is to keep in mind that this kind of thinking is not a lucky knack but a system that *can* be taught and learned. The molecular biologists today are living proof of it. The second thing is to be explicit and formal and regular about it, to devote a half hour or an hour to analytical thinking every day, writing out the logical tree and the alternatives and crucial experiments explicitly in a permanent notebook. I have discussed elsewhere (*3*) the value of Fermi's notebook method, the effect it had on his colleagues and students, and the testimony that it "can be adopted by anyone with profit."

It is true that it takes great courtesy to teach the method, especially to one's peers—or their students. The strong-inference point of view is so resolutely critical of methods of work and values in science that any attempt to compare specific cases is likely to sound both smug and destructive. Mainly one should try to teach it by example and by exhorting to self-analysis and self-improvement only in general terms, as I am doing here.

But I will mention one severe but useful private test—a touchstone of strong inference—that removes the necessity for third-person criticism, because it is a test that anyone can learn to carry with him for use as needed. It is our old friend the Baconian "exclusion," but I call it "The Question." Obviously it should be applied as much to one's own thinking as to others'. It consists of asking in your own mind, on hearing any scientific explanation or theory put forward, "But sir, what experiment could *dis*prove your hypothesis?"; or, on hearing a scientific experiment described, "But sir, what hypothesis does your experiment *dis*prove?"

This goes straight to the heart of the matter. It forces everyone to refocus on the central question of whether there is or is not a testable scientific step forward.

If such a question were asked aloud, many a supposedly great scientist would sputter and turn livid and would want to throw the questioner out, as a hostile witness! Such a man is less than he appears, for he is obviously not accustomed to think in terms of alternative hypotheses and crucial experiments for himself; and one might also wonder about the state of science in the field he is in. But who knows?—the question might educate him, and his field too!

On the other hand, I think that throughout most of molecular biology and nuclear physics the response to The Question would be to outline immediately not one but several tests to disprove the hypothesis—and it would turn out that the speaker already had two or three graduate students working on them!

I almost think that government agencies could make use of this kind of touchstone. It is not true that all science is equal, or that we cannot justly compare the effectiveness of scientists by any method other than a mutual-recommendation system. The man to watch, the man to put your money on, is not the man who wants to make "a survey" or a "more detailed study" but the man with the notebook, the man with the alternative hypotheses and the crucial experiments, the man who knows how to answer your Question of disproof and is already working on it.

There are some really hard problems, some high-information problems, ahead of us in several fields, problems of photosynthesis, of cellular organization, of the molecular structure and organization of the

nervous system, not to mention some of our social and international problems. It seems to me that the method of most rapid progress in such complex areas, the most effective way of using our brains, is going to be to set down explicity at each step just what the question is, and, what all the alternatives are, and then to set up crucial experiments to try to disprove some. Problems of this complexity, if they can be solved at all, can be solved only by men generating and excluding possibilities with maximum effectiveness, to obtain a high degree of information per unit time —men willing to work a little bit at thinking.

When whole groups of us begin to concentrate like that, I believe we may see the molecular-biology phenomenon repeated over and over again, with order-of-magnitude increases in the rate of scientific understanding in almost every field.

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To Orient or Not to Orient--That Is the Question

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MUCH time and effort has been spent in considering orientation programs. There have been some false starts and much energy has been expended with seemingly ineffective results. Now we need to find the effective means to explain the purposes, operations and machinery of the Indiana State Medical Association—and its usefulness—to our members.

The very existence of the state medical association may depend upon comprehensive understanding by its membership, both new and old, of the association's objectives and purposes.

Perhaps, then, before embarking on another action program for orientation of new members, it would be well to delineate some of the basic human motivational factors involved and develop an understanding of what we are trying to do. This may be tedious and even a little rankling because it will bring each of us face to face with the inadequacies of his own experience. We all tend to be defensive and unrealistic when assessing our own experience. The employment of an objectivity that eliminates individual defenses—an objectivity described in the article "Strong Inference" reproduced elsewhere in this issue of *The Journal*—might be the thing that would make development of an orientation program effective for the Indiana State Medical Association.

So, the first and perhaps most vital approach to any orientation program is the thorough and good-natured understanding that we all have areas of inadequate experience. The accurate assessment of this factor—inadequate experience in ourselves, the planners, and the persons we are trying to orient—may determine the ultimate success of the operation.

Having assessed ourselves a little, the next step is to thoroughly understand and accurately pinpoint those whom we are trying to orient—besides ourselves.

Who are the new members of the state medical association? For that matter, who are the present members? Being a general practitioner of medicine and presumably not a scientist, I am somewhat amazed that the scientific community has not raised this question before.

A little review of the present membership roll reveals the following distribution of members among the various types of practices:

INDIANA

Direct Patient Care

TOTAL PHYSICIANS	4,516
GENERAL PRACTICE	1,772
MEDICAL SPECIALTIES	663
Allergy	17
Cardiovascular dis.	19
Dermatology	48
Gastro-enterology	1
Internal medicine	396
Pediatrics	165
Ped. cardiology	1
Pulmonary dis.	16
SURGICAL SPECIALTIES	1,231
General surgery	432
Neurological surgery	28
OB-gyn.	213
Ophthalmology	171
Orthopedic	137
Otolaryngology	99
Plastic	21
Colon & rectal	13
Thoracic	17
Urology	100

OTHER PROFESSIONAL ACTIVITY	
Medical school faculty	145
Administration	39
Research	78
Interns	113
Residents and fellows	292
Full-time hospital physician staff	195
	862
OTHER SPECIALTIES	850
Anesthesiology	199
Child psychiatry	9
Forensic path.	1
Neurology	18
Occupational med.	41
Psychiatry	163
Pathology	120
Physical med. & rehab.	6
Gen. preventive med.	5
Public health	9
Radiology	182
Not recognized	9
Unspecified	88

* Member, ISMA Commission on Special Activities.

It can be assumed that new members will have somewhat the same distribution. Since the distribution of the new members from year to year is unknown beforehand, the breakdown of the present membership is the best guide to what the association will have as an audience for orientation.

This certainly represents a variety of interests and is a little disquieting. How do you formulate an orientation program directed to this great complexity of experiences? Perhaps the next logical step would be to recognize the common factors in these doctors' experiences.

The first and most common attribute of experience is that we are all human beings, possessed with all the perplexing, interesting, sometimes seemingly inconsistent, sometimes amazingly consistent, inscrutably unpredictable characteristics. In other words, doctors are people first, doctors, scientists, educators, etc., second.

So, the next criterion any orientation program should be judged by is —does this program approach its audience as people? Here we could use the experience of public relations experts.

The second common characteristic is that we are all graduates of medical schools and have pursued the courses that were thought to be necessary to attain an M.D. degree. Certain common experiences and characteristics have been shared by all of us—could we not appeal to these common denominators?

There is no doubt there must be a common motivational factor in anyone's entrance into the healing art in the first place. Perhaps this is the basic desire to help people. Perhaps it is a basic desire to dominate people. Perhaps it is the basic motivation involved with relating to other people rather than one involved with "things," as pursuits in pure knowledge, engineering, money and economics are. Therefore, any orientation program for physicians should utilize and be undergirded by these basic motivating factors.

There is no doubt that, in the process of pursuing the studies necessary to become an M.D., a doctor misses many of the experiences in interpersonal people-to-people relationships. Others acquire these relationships by being more involved in the everyday exchanges and experiences during their formative years which makes them more comfortable with personal interchanges than doctors are, generally. It may be this area of inadequate experience that makes the attitudes of some lay persons—especially towards medicine—incomprehensible to doctors. And also doctors' defenses so incomprehensible to people.

The favored position the doctor occupies from the day he decides to study medicine is his greatest handicap when it comes to dealing with people on a face-to-face basis. And it may be what accounts for his collective poor public image. If the doctor, then, could only realize that he may lack experience in areas of people-to-people interrelationships, and that as a result he is reading meanings into any questioning of his conduct or motives that are simply not there, he would be able to construct defenses that are much more realistic and within the realm of people's understanding.

Any orientation program for physicians should incorporate an appeal to some of the areas of inadequate experience and relate them to realistic attitudes of people in a way that is comprehensible to all. This, I'll admit, is a large order but success depends on accomplishing it to a fair degree.

In this article I have tried to call attention to some of the things that make our efforts toward an effective orientation program perplexing to us. Of course, this represents only one man's opinion and perhaps is more individual defense—but I hope it presents a framework of thinking that can encourage more realistic expressions from more doctors on just what a good orientation program should consist of. In this way a really effective orientation program can be developed. ◄

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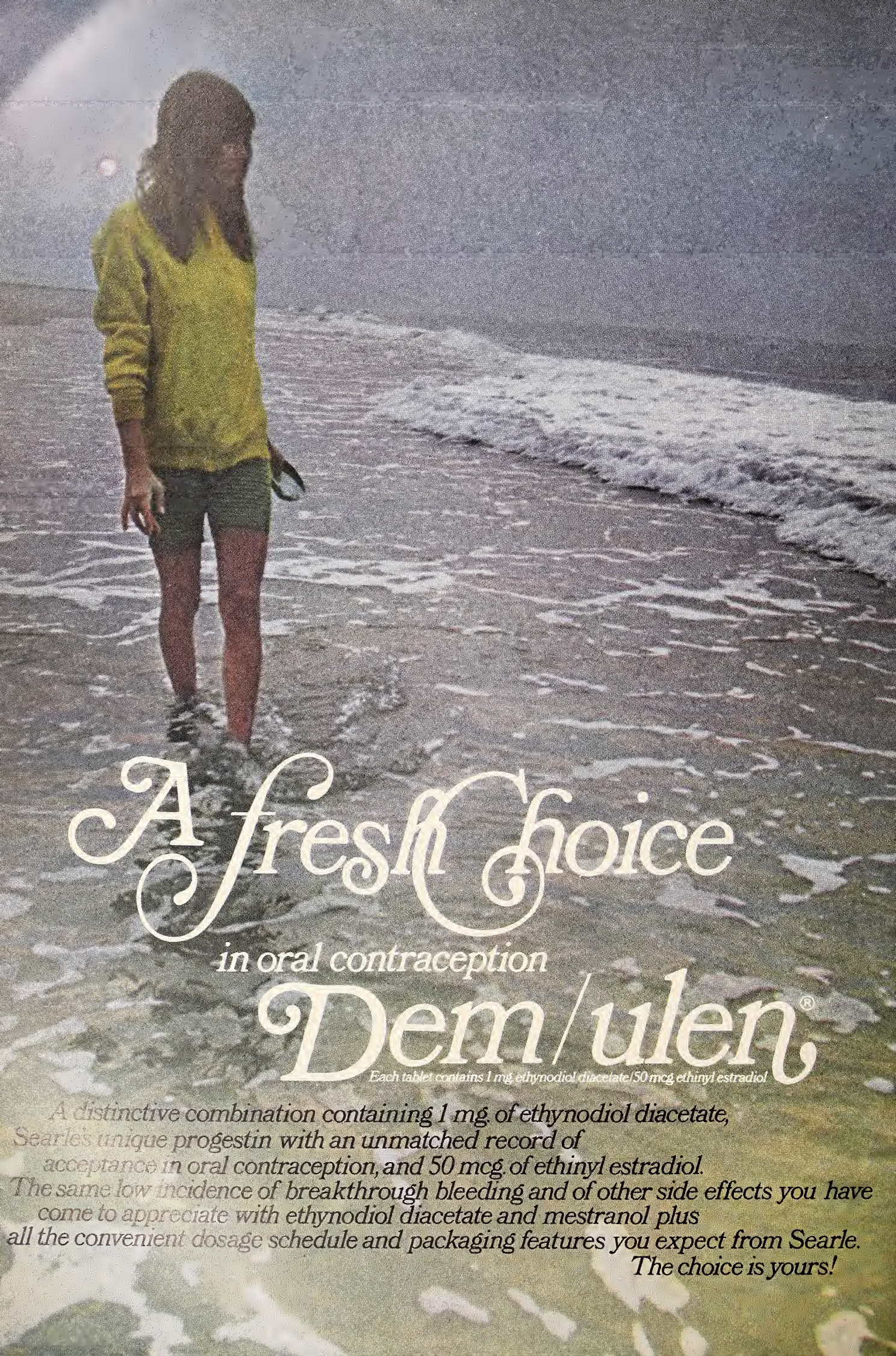
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Chicken Noodle	54	Cream of Mushroom	115
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Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions; neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

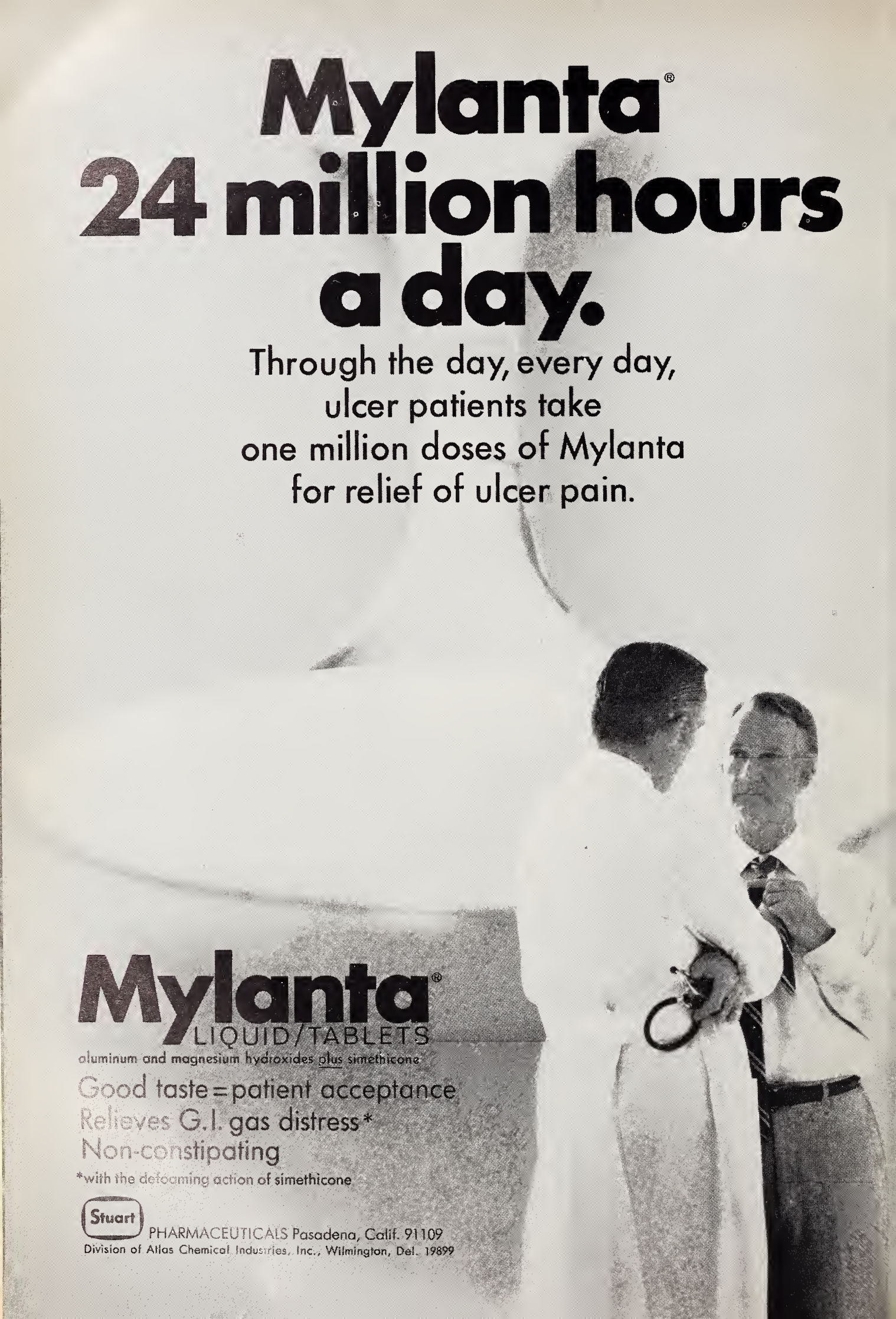
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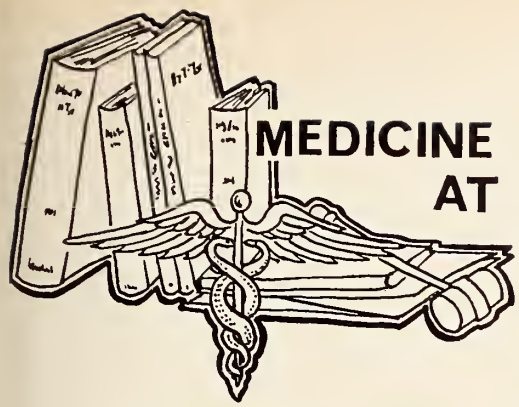
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MEDICINE AT LAW

Debtor Cannot Claim "Fifth" in Suit for Hospital Charges— Requiring a debtor to testify for a hospital in a suit to recover the balance due from her for services was held not to violate her constitutional right against self-incrimination, under the Fifth Amendment. The ruling was made by the Supreme Court of Vermont.

The hospital sued a mother for a $70.60 balance due for services rendered to her minor son. The original bill was $330.80, of which $220.60 was paid by an insurance company.

At the trial, the hospital called the mother as a witness for the purpose of establishing its case against her. She objected but said she would testify if the court wanted her to do so. The judge then told her that she could be called as a witness. She did not invoke the Fifth Amendment privilege by declining to answer any questions upon the ground that her testimony would tend to incriminate her.

Under court rules, the hospital had the right to question the debtor on any material issue. The privilege not to give self-incriminating evidence, the court said, does not exist for practical purposes unless claimed by the person entitled to it. It is a privilege only to refuse to testify to a fact tending to prove the commission of a crime by the witness or disclosing a source from which evidence of such crime might be obtained.

Nothing in the testimony even remotely inferred a criminal offense, the court said. A witness may not refuse to answer because the answer might expose him to a civil action or financial loss, as by tending to prove a debt.—*Heaton Hospital, Inc., v. Emrick*, 264 A.2d 806 (Vt. Sup.Ct., April 7, 1970).

Report of Hospital Committee Subject to Inspection—A monthly report prepared by a hospital committee, containing a monthly summary on deaths of new-born infants, was ordered by a New Jersey trial court to be produced for inspection.

Inspection of the report was sought by parties who had brought suit alleging that the negligence of hospital personnel had caused the death of their new-born infant.

The report had been prepared by a committee of the hospital's department of obstetrics and gynecology more than a month after the infant's death. It noted facts, cause of death, and autopsy findings concerning the infant. The report was not a part of the patient's record but was a monthly summary reporting on infant deaths at, or shortly after, delivery.

A state statute provided for the inspection and copying of non-confidential books and papers in the possession of an opposing party. The hospital contended that the report was a confidential internal communication and that it did not relate to the care and treatment of the patient.

The court held that the report must be produced despite the fact that it was not a part of the infant's record and was not made during the course of treatment by the treating physician. The court pointed out that the report contained a capsulized finding as to the infant's condition and the cause of death. It was further noted that, although it was questionable whether the matters contained in the report were admissible in evidence, still the report could lead to the discovery of admissible evidence. The court ruled that internal records and reports which are otherwise confidential are subject to inspection if they are relevant to the subject matter of a suit or if they may lead to the discovery of material evidence.—*Gureghian v. Hackensack Hospital*, 262 A.2d 440 (N.J. Super. Ct., Feb. 19, 1970).

Hospital Held not Liable for Failure to Give Enema—A jury's verdict that a hospital's alleged failure to administer an enema prior to a hysterectomy was not the cause of the patient's subsequent maladies was sustained by the highest court of Alabama.

The patient testified that she was supposed to be given a Fleet's enema before the surgery. She denied receiving the enema, and said that, before the operation, she had complained of not receiving the enema.

The head nurse attended the patient before the surgery, but she was "in and out of the room." She stated that the patient did not complain to her about not having an enema, but that she seemed apprehensive. In the post-operative period, however, she did complain about not having received the enema.

The head nurse testified that before surgery she checked to be sure that the patient had the enema. She said that a student nurse wrote down the order and that the package in which the enema comes was gone.

The surgeon testified that she did order the Fleet's enema but that if it had not been given it would not have been harmful or affected the surgery. She stated that the opera-

tion was a complete success and that the first time the patient complained to her that she had not received the enema was five or six days after the operation. The surgeon said that nothing the hospital did or failed to do caused any injury to the patient while at the hospital, nor would the failure to receive a Fleet's enema have resulted in any of her later complaints.

The patient's personal physician, a general practitioner, stated that he was familiar with her complaints and would not say that any of these complaints were attributable to a failure on the part of the hospital to properly care for her. He also stated he could not relate her present ailments to a failure to give a Fleet's enema. The judgment for the hospital was affirmed.—*Blair v. St. Margaret's Hospital*, 235 So. 2d 668 (Ala. Sup. Ct., May 15, 1970).

"Pill" Manufacturer Liable for Necrosis of Hip Joint—A husband and a wife won a suit in a federal trial court against a manufacturer of a contraceptive pill because the drug allegedly caused the woman to suffer circulatory impairment of the hip joint, resulting in degeneration of the head of the femur.

The 34-year-old housewife claimed that after taking the pill she had repeated episodes of thrombophlebitis which caused asceptic necrosis of the head of the femur, necessitating removal of the bone and replacement with an Austin-Moore prosthesis. She contended that the company negligently failed to disclose full information about the pill's dangers to physicians and to the public.

Allegedly, her right hip has been permanently crippled and she suffers constant pain. A physician who testified in favor of the manufacturer said that the hip disability was unrelated to the circulatory disorder. —*Tobin and Tobin v. G. D. Searle and Co.* (D.C., Mich., Docket No. 25664, 1970).

Physician Who Reported Suspected Child Abuse Held Immune from Suit—In a suit brought by the parents of a four-week-old infant, summary judgment was granted in favor of a hospital and two physicians who were accused of acting in bad faith in filing a report stating that they suspected that the parents had intentionally inflicted injuries on the child. The examining physician had written the report, and the hospital and a physician who allegedly supervised him were charged with being vicariously liable. Michigan law requires a physician to report a case of suspected child abuse to the appropriate state agency. The statute grants immunity from civil liability to a person who makes such a report in good faith. The parents' suit was dismissed by a Michigan trial court because the parents failed to rebut a statutory presumption that the physicians had acted in good faith.

The infant was taken to the hospital as an emergency patient. An examination revealed that he had sustained fractures of the skull and the clavicle. Because the child's condition was serious, immediate surgery was required. At the time, the parents were unavailable for consultation with the physicians.

Since the examining physician suspected that the child had been abused, he filed a report of the injuries. The Michigan statute provides that any licensed physician who gives medical treatment to a child under 17 years of age who has physical injuries which were or may have been inflicted upon him by any person responsible for his care must immediately make a report. The report is sent to a state social service agency. The statute also says that when the attending or examining physician is a member of a hospital staff, he must notify the person in charge of the hospital.

The law further provides that all persons acting in good faith in making such a report will be immune from civil or criminal liability, and any person making or assisting in the making of the report will be presumed to have acted in good faith.

The statute does not require the reporting party to make any investigation beyond the initial examination. Further investigations are to be carried out by the State Department of Social Services in cooperation with the county prosecuting attorney and the probate court.

The child's parents contended that there was an issue of fact as to whether the physicians and the hospital had acted in good faith. The parents also argued that a physician should be required to make a searching investigation before reporting a case of suspected child abuse. The physicians and the hospital said that the parents had failed to rebut the presumption of good faith in making the report.

The court referred to a Michigan Supreme Court case which held that to overcome the presumption of good faith, the circumstances must be such as to show that the individual was actuated by a bad motive. The court held that the statements of the parents alleging bad faith were mere conclusions and that no genuine issues of fact were presented. Therefore, summary judgment was granted for the physicians and the hospital. —*Haewsky v. St. John Hospital, Doane, and Burton*, (Mich. Cir.Ct., Wayne Co., Docket No. 136,064, June 10, 1970). (Reference: Norman Sommers, Esq., Bizer, Sommers and Gordon, P.C., 1440 First National Bank Bldg., Detroit, Mich. 48226).

No Liability for "Burn" Scar on Elbow after Gallbladder Surgery—A hospital, surgeon, and an anesthetist were not liable to a woman who claimed that while undergoing gallbladder surgery, she suffered a "burn" on her elbow, a

California trial court held. The alleged wrongdoers contended that the injury was caused by extravasation and that this can occur even though due care is used.

The patient alleged that the parties negligently allowed the "burn" to occur and that they should be held liable under the doctrine of *res ipsa loquitur*. The requirements for this theory to apply are: (1) the event must be of a kind which ordinarily does not ocur in the absence of negligence, (2) it must be caused by an instrumentality in the exclusive control of the alleged wrongdoer, and (3) it must not have been due to any voluntary action of the patient.

The physicians denied that any mishap took place during the surgery. They testified that the patient had difficult veins and that several extravasations of injections occurred.

The woman alleged that, as a result of the injury, the arm is weak and she is unable to work. She claimed that there is a residual scar on the elbow. The surgeon said that the scar was minimal and that any pain was not related to the scar or the extravasations.—*Givern v. Levin, Harris, and Mt. Zion Hospital* (Cal. Super. Ct. San Francisco Co., Docket No. 575016, 1970).

Patient's Husband Liable for Assaulting Nurse's Aide—A hospital patient's husband who allegedly assaulted a nurse's aide because she failed to respond promptly to a call for service was held liable by a California trial court.

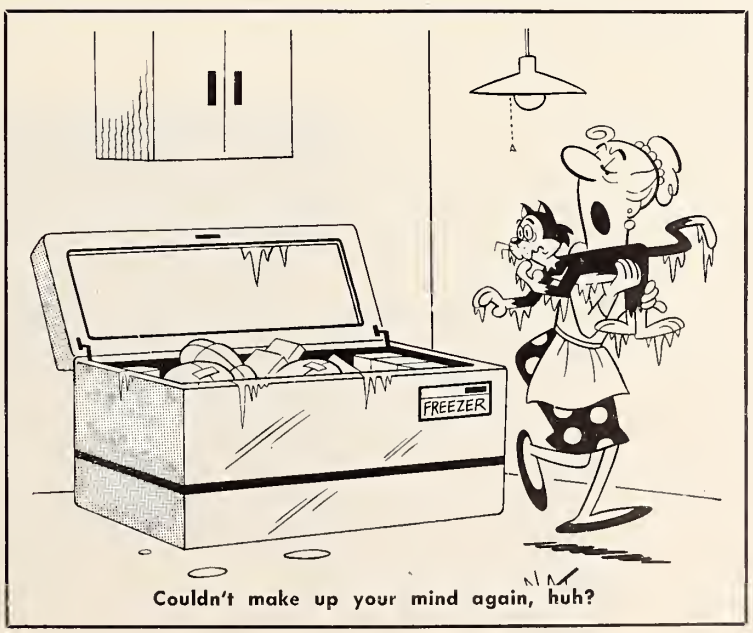
The aide claimed that she attemped to explain to the visitor that the call had not been answered because the nurses were extremely busy. She stated that he then pushed her against the door and out of the room.

The accused man contended that he went to get help for his wife after there was no response to the signal light. He stated that two nurses's aides were talking in the hall and that they refused to attend to the patient, claiming that they were too busy.

The husband asserted that he took one of the aides by the arm and that she jerked away and told him never to touch her again.

The aide alleged that as a result of the incident she had bruises on her arm, which cleared up in three weeks, and that she sustained a back injury which was noticeable two to three months after the alleged assault.

The jury awarded the nurse's aide $2,000 but declined to award punitive damages.—*Kaiser v. Ross* (Cal. Super.Ct., Santa Clara Co., Docket No. 222560, 1970). ◄



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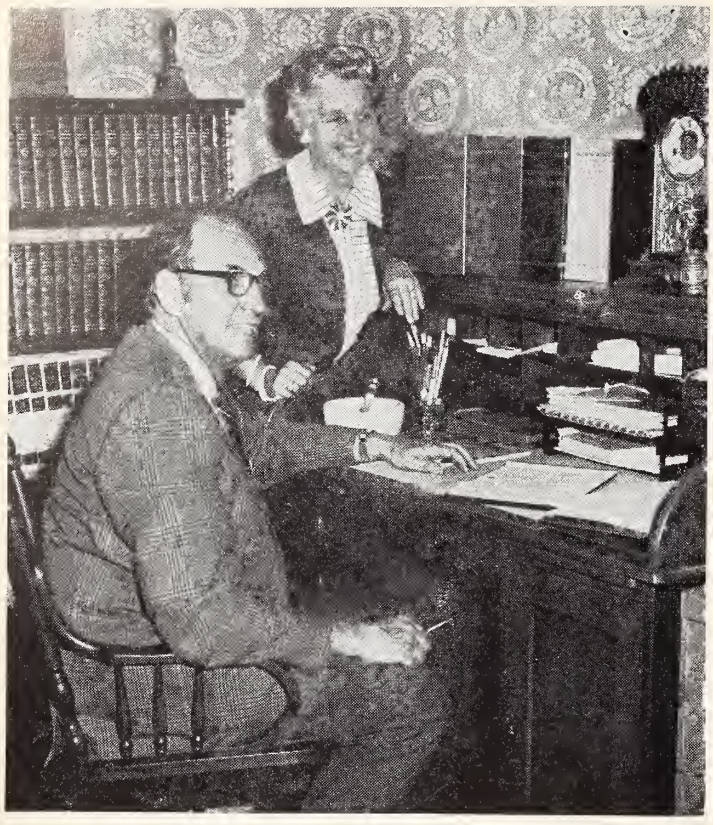
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I certify that the statements made by me above are correct and complete.

James A. Waggener
Business Manager



DR. and Mrs. Malcolm Scamahorn in his study at their home in Pittsboro.

Introducing

Malcolm O. Scamahorn, M.D.,
President, Indiana State Medical Association
1970 - 1971

DR. MALCOLM, as he is called in his practice area, comes to the presidency after years of service to organized medical associations. Born the younger son of the late Dr. O. T. and Fannie Scamahorn of Pittsboro, he attended Indiana University and returned after service in World War II to practice in Pittsboro.

At college he met, courted and, in medical school, married his attractive and personable wife, Wilma Jean. She has been his helper in practice and outstanding in her work at the Woman's Auxiliary state office level.

Dr. Malcolm has served in all offices of the Hendricks County Medical Society, the Seventh District Society and in several capacities on the state level. A solo family practitioner, he has been active, too, in the Academy of General Practice, and chairman of the G.P. Club for three years. This club augments the preceptorship program of ISMA and the I.U. School of Medicine, "soft sells" family practice and urges the students to practice in Indiana.

Interested in youth, Dr. Malcolm had the first preceptorship student and subsequently six others. His family has also hosted exchange students from Germany, France and Peru.

Wilma Jean and Dr. Malcolm's proudest accomplishments are their three children. Their daughter Jean Abbott, who lives nearby with husband Jerry and the Scamahorn's only grandchild, Debbie, teaches homemaking. John and his recent bride, Mary Jane, live near the Purdue campus where John is a third-year student in veterinary medicine. Mary Jane teaches special education at Delphi. Jim is a sophomore in honors division of pre-medicine at Indiana University and plans to start medical science-medical school combination next year.

The Scamahorn's home with acreage in Pittsboro is a white frame house towered over by beautiful maples. The interior is tastefully decorated in French Provincial style which is highlighted by several beautiful family and acquired antiques. Throughout the house one feels the livability of the home and active family usage.

Both Dr. Malcolm and Wilma Jean teach Sunday school classes of youth and are otherwise active in their local Christian Church. Dr. Malcolm has also been active in retreats with I.U. Medical School students, was a Scoutmaster for two years and an active Scouter for 20 years. His



AN informal chat with students at the recent Indiana University-ISMA retreat.

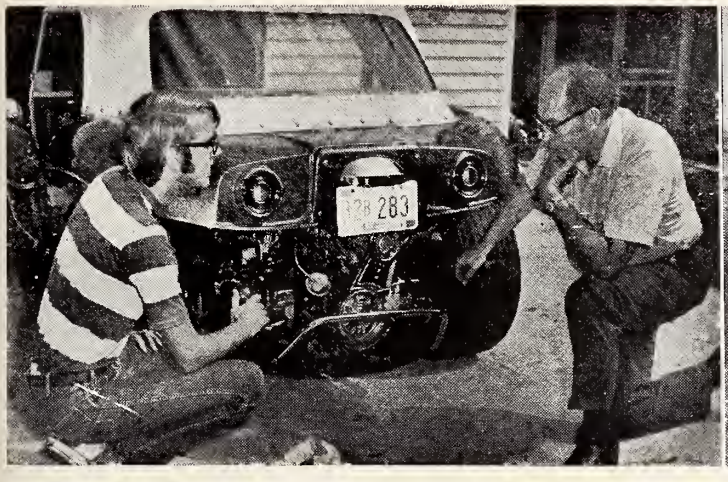
hobbies include working on dune buggies, swimming, photography, raising ponies and beef and entertaining his granddaughter.

During his tenure as president-elect his office staff has adapted to his schedule and he considers himself fortunate to have associated with him until mid-1971 a classmate and returned medical missionary to Africa, Gerald Fisher, M.D.

The Journal and the Indiana State Medical Association are proud and pleased to introduce Dr. Scamahorn and to have the Scamahorns as the First Family of Indiana Medicine for 1970 - 1971.



ALERT teenagers make up the Sunday School class Dr. Malcolm teaches at the Pittsboro Christian Church.



JAMES Scamahorn consults with his father about further work to be done on a dune buggy.



DEBBIE ABBOTT takes her grandfather for a ride behind one of the ponies he raises.



THE entire family poses for a picture after the wedding of John and Mary Jane in September 1970. In the foreground is Debbie Abbott, and behind her are the bridegroom, the bride and Mrs. Scamahorn. In the back row are son James, son-in-law Jerry Abbott, daughter Jean Abbott and Dr. Malcolm.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

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With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

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5 mg chlordiazepoxide	5-4	0.4 mg water-soluble esterified estrogens
10 mg chlordiazepoxide	10-4	0.4 mg water-soluble esterified estrogens

The Woman's Auxiliary

REPORTS TO ISMA

The busiest time of the year for Auxiliary work is in the fall and, to make us more enthusisatic and exhilarated, we have the most gorgeous season to accompany our work.

One of the most rewarding things about the year of being President of the Auxiliary is this very fact that I can travel around and see the Midwest in the most beautiful time of the year.



We had a most successful combined Workshop in Indianapolis in September. We had a good attendance and very interesting officer and chairman reports. We had good discussion and many new ideas presented. Our luncheon speaker, Dr. Otis Bowen, gave a very informative talk on legislation.

The more good meetings we have, the more we retain of what we learn. In other words, the more we come together, work together, and keep together, the more successful will be our Auxiliary goals.

We were very happy to hear at the AMA in June that we had done so well on our AMA-ERF donations. We usually make the earning of funds for this project our top priority for the year in our county Auxiliaries. We are trying so hard to make our image that of a service organization and not strictly social. This year our National President, Mrs. R. C. L. Robertson, has made her theme "Community Service." To become involved in our community broadens our knowledge and scope of activities. It also helps our husbands because, the more people we meet, the more opportunity we have to "tell it like it is." We can tell the facts to all who will listen. The most important thing for us is to be well informed, and this is where our meetings can help us.

We are looking forward with anticipation to our next meetings. Our National Conference for Presidents and Presidents-elect in Chicago, followed by our exciting programs for the women so aptly planned by Gwen Stiver in South Bend at the ISMA; then back to Chicago for the North Central Workshop for Officers and Chairman. It will be a busy week and I hope I can absorb at least a goodly portion of all that will be offered me.

Again we are always thankful to the ISMA staff and their facilities. They are so cooperative when we need them. Of course you doctors are always cooperative, too, and we truly are thankful.

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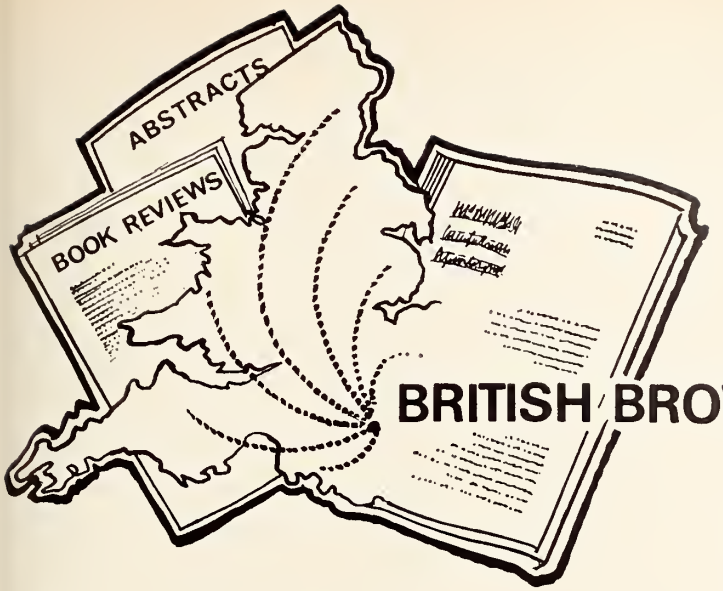
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STEVEN C. BEERING, M.D.
Indianapolis

Lung Biopsy

Lung biopsy has been used as a diagnostic tool for approximately 20 years now. There has been a mounting interest in diffuse infiltrative disease of the lungs and the fond hope that a piece of tissue would yield not only the diagnosis but also a clue as to appropriate therapy. Dr. J. G. Scadding, Professor of Medicine, Institute of Diseases of the Chest, Brompton Hospital, London, in the Tudor Edwards Memorial Lecture describes his 13 years of experience with the lung biopsy. It is surprising that he used lung biopsy on only 43 occasions. The diagnoses reached were alveolitis (27), sarcoidosis (15), eosinophilic granuloma (5) and malignant disease (4); the specimen did not yield a diagnosis in another eight cases. Dr. Scadding mentions that one of the criteria for lung biopsy has always been that there should be treatable disease in the differential diagnosis. While this still holds for localized pulmonary disorders, most of these are now identified in frozen section at thoracotomy. It is only rarely that lung biopsy reveals such conditions as periarteritis nodosa or chronic pneumonia. Dr. Scadding writes "though biopsy may occasionally provide the opportunity for demonstration of the causal agent of a disease defined in terms of etiology, in my series there was no instance of this. This is due largely to selection; I take every step to exclude diseases whose causal agent can be isolated by other procedures before I advise lung biopsy."[1]

Extra Articular Manifestations of Rheumatoid Arthritis

Dr. F. Dudley Hart in the Stanley Davidson lecture, Aberdeen, Scotland, describes in rich detail the protean manifestations of rheumatoid disease. "The bursae of the body tend to be forgotten: they are the lost souls of rheumatology, but they make their presence unpleasantly obvious all too often. . . . 156 potential areas of inflammation and pain in the body should not likely be disregarded." In addition to reviewing bursitis, Dr. Hart describes synovial rupture, the psychiatric aspects of rheumatoid disease, infections in rheumatoid patients, Felty's syndrome, liver disease, osteoporosis, coronary arteritis and thyroid disease. His description of the mortality in rheumatoid arthritics is particularly striking: "A severe rheumatoid arthritic dies, as it were, by inches and it is hard in such crippled, ill, anemic, hypoproteinemic patients to say which of several factors have been the major ones in causing death. Such a patient may take many years to die; her condition slowly and insidiously worsening over a long period. The terminal pneumonia or coronary occlusion merely striking down one already, as it were, on her knees." He points out that death, when it occurs, is not so much due to specific complications of rheumatoid arthritis as from all the usual causes although occurring at a much earlier age. Dr. Hart concludes with the admonition that since rheumatoid artritis is not a curable disease, we physicians must take care not to add to its morbidity by the injudicious use of drugs such as high-dosage steroids.[2]

Phenformin in Insulin-Dependent Diabetics

More than a dozen years of clinical experience is now available in the use of phenformin in diabetics. Its value has been established in maturity-onset diabetics not requiring insulin. The sporadic enthusiasm for its use in brittle or juvenile diabetics has been counteracted by the high incidence of side effects notably gastrointestinal difficulties. The mode of action of phenformin is not yet fully understood but unlike the sulphonylureas it can lower blood sugar in the absence of a functioning

pancreas. In labile diabetics or the intermediate type diabetics, phenformin has been shown to reduce insulin requirements by a number of investigators.

Drs. Arnold Bloom and R. J. Kolbe of the Whittington Hospital in London studied 41 diabetic patients whose average age was 39 and who were almost equally divided between male and female patients. The mean duration of their diabetes was 10 years and the mean insulin requirement was 52.7 units daily. Forty-one of these patients were given 100 mgm of phenformin as the time-delay capsule for six weeks each either before or after a period of six weeks of inert capsules. Eleven patients noticed hypoglycemic effects and reduced their insulin on an average of almost 20% without any resultant rise in the blood sugars. Twenty-eight patients felt no untoward effects and maintained their usual insulin dose. Generally speaking the addition of phenformin capsules led to improved control of the diabetes with a significant decrease in blood sugar levels and a significant reduction in the variability in the weekly blood sugar readings. There was no increased ketosis, no change in the serum cholesterol, no significant weight loss and no gastrointestinal or other side effects. The blood sugar fluctuations were greatly diminished. It is suggested that the addition of phenformin therapy in insulin dependent diabetics could offer material advantages over control on insulin alone.[3]

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3. Bloom, A. and Kolbe, R. J. Phenformin in Insulin-dependent Diabetics, *Brit. Med. J.* 1:660-662, 1970. ◄

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—September 1970

Disease	Sept. 1970	Aug. 1970	July 1970	Sept. 1969	Sept. 1968
Animal Bites	845	1175	1470	913	900
Chickenpox	26	20	36	31	49
Conjuctivitis	127	125	157	74	97
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	37	55	26	5	19
Gonorrhea	754	753	824	656	555
Impetigo	243	190	171	176	247
Infectious Hepatitis	41	52	45	46	29
Infectious Mononucleosis	61	29	44	36	46
Influenza	543	338	206	588	701
Measles					
Rubeola	5	5	22	1	8
Rubella	57	60	77	26	36
Meningococcic Meningitis	0	3	0	1	6
Meningitis, Other	7	2	3	3	2
Mumps	63	63	103	56	76
Pertussis (Whooping Cough)	15	14	15	8	21
Pneumonia	198	220	209	139	101
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	512	418	455	333	331
Syphilis					
Primary & Secondary	21	34	38	39	29
All Other Syphilis	103	114	170	85	121
Tinea Capitis	5	5	1	3	13
Tuberculosis (Active)	65	70	102	62	83

Need for AMA Dues Increase Explained

EDITOR'S NOTE: Following is the second in a series of original articles prepared by the American Medical News citing the need for an AMA dues increase as voted recently by the House of Delegates. Answering the questions are Burt L. Davis, M.D., chairman of the Finance Committee of the Board of Trustees, and Max H. Parrott, M.D., chairman of the AMA Board of Trustees.

Q. Dr. Davis, during the Annual Convention last June there was some criticism of AMA's budgeting and accounting practices. What actions are being taken along those lines?

A. I think we're making progress. A little over a year ago, we established a controllership function as part of our management team, and since then we've made real strides toward establishing a system that will give us both budgetary and accounting information on both divisional and program bases.

Q. Can you spell out other objectives of this new function?

A. We're moving toward formalizing accounting, purchasing, personnel, and other business activities of AMA into a standard practice manual. An internal audit department will be established to examine, review, and appraise our existing procedures and how well we're following them. Then we can identify and correct deficiencies in procedures and/or performance.

Q. What improvements can we look for from the accounting area?

A. The principal goal at the moment, other than the aforementioned strengthening of our system of internal control, is in the area of broadening the base of financial data available to AMA management. With such additional information available, the Board will be able to better allocate AMA resources to meet our goals and objectives.

Q. Can you elaborate on this point?

A. At present, the AMA budget system is confined to a "responsibility" budget, in which each department and division submits its proposed budget. That budget is reviewed and revised, when appropriate, at the divisional level, by the executive vice president, the Finance Committee, and finally by the Board of Trustees.

The budget is then fed into the computer and comparisons are made between actual spending and budget allocations on a quarterly—and year-to-year basis. Periodic review and analysis is made of significant variances from the budget, and the reasons for such variances are analyzed. In that way, the current procedure provides adequate control over financial transactions of the AMA, and each of its operating divisions.

This system, however, does not give us budgetary data and control with respect to costs of specific activities. Since each division is involved in a number of activities, it is necessary to break the divisional budget out by activities and to record actual transactions in the same manner.

Q. When will this be accomplished?

A. Preliminary steps have been taken in connection with the 1971 budget which is now being prepared. We hope that the 1972 budget will be prepared in both "responsibility" and "activity" format.

Q. What are the obstacles?

A. A major one is to clearly identify the goals and objectives of AMA and to further break these into programs. A considerable amount of systems design will be required in the operating, accounting, and data processing areas. Also, the staff will have to be familiarized with the new procedures.

However, you have to keep in mind one important factor. No matter how efficiently the AMA's finances are managed, the operation of this Association is an expensive business.

As the health care industry grows, AMA must grow right along with it if we are to continue to maintain a leadership role. How much of this we can do largely depends on the support we get from the nation's physicians. But we're convinced that AMA has become an effective, progressive spokesman for medicine, and we're confident that the profession will continue to support the AMA—both financially and philosophically.

Q. Dr. Parrott, what's ahead for the AMA?

A. Two years ago, the House of Delegates approved a statement calling for intensified leadership from the AMA in areas of public concern. And I'm sure you're aware of the increased public concern about all kinds of medical problems—physician shortages, national health insurance, the environment, nutrition, and health care delivery, as examples. Physicians have a great deal of expertise in areas like this, and if medicine doesn't provide the leadership in finding solutions, we're likely to be left with the job of trying to salvage programs designed by people

without real awareness of the medical problems involved.

As I see it, that's half of our role in the future. The other, which is equally important, is service to the profession. Of course, the two interrelate in many areas.

Q. Can you give some examples?

A. One of the most important is medical education. When school began this year, there were 103 medical schools; in 1960 there were 85. Internship and residency programs also are increasing. Since the days of the Flexner Report, AMA has been a major influence in the course of medical education. If we're going to continue, we have to expand our programs.

What we do in medical education naturally has great effect on medicine, so the public has an equally important stake in the outcome.

Q. What about new areas of service to members?

A. One important one is in audio-visual production, which would enable AMA to provide continuing medical education material for medical societies, hospitals, and individual physicians, along with patient-instruction and socioeconomic films.

Another is development of a professional liability insurance program under AMA sponsorship, along with national educational campaigns on claims prevention and patient safety. The Board outlined quite a list of them in its report to the House last June.

Q. It seems that one of the most frequent questions from MDs is "What am I getting for my $70?"

A. The list of tangible services is a long one—including the AMA's publications, medicolegal information, scientific films and an outstanding scientific library service, drug information, practice management advice, a group disability insurance program, and a members' retirement plan. These are just a few, but their value—if you could measure it in dollars—would be a lot more than a member pays in dues.

However, we feel the intangible benefits are worth even more. Most of AMA's work is devoted to helping the physician practice better medicine—that's a major goal of our publications and scientific programs. And we have many dedicated members who serve on councils and committees and devote a lot of their time to evaluating the changing world of medicine—both from scientific and socioeconomic aspects.

Another factor that's hard to measure is AMA's role in such things as accreditation of hospitals and educational programs, and in medical ethics work. All these things are very important to medicine—they have to be done, and if the profession doesn't do them, someone else will have to.

Current AMA expenditures show only 11.2% listed as "services for members." However, that doesn't include our educational and scientific activities, scientific publications, and public affairs activites, much of which is really membership service. In fact, everything we do is membership service, because the members give the orders and make the policy—the Board and House carry out those instructions.

We've figured out that if members had to support the entire cost of AMA's activities, dues would have to be $188 a year. But even for $188 a year, members couldn't purchase what they're getting—in fact, they probably couldn't purchase it at all. What they're getting is the vast experience and skills of a central organization. Furthermore, the individual physician, when he pays his dues, is becoming a part of a strong, unified voice on national issues affecting our patients and our profession.

Q. And you feel this is the most important factor of membership?

A. All the factors are important. But let me say this. Dr. Davis (Burt L. Davis, M.D., chairman of the AMA Finance Committee) and I have been talking to you about dues. Now, it's easy to make all kinds of comparisons—AMA dues as compared with union dues, specialty society dues, American Bar Association dues, etc.—but we don't feel these are relevant. The AMA is a unique organization fulfilling a special function—it is the physicians' national organization, and the dues for next year—$110, or just over $9 a month—are necessary to do the job that our members, through their elected delegates, have decided are necessary.

When a physician pays dues to the AMA, he's making a membership investment; this investment creates a unifying factor which in turn helps create a more concerned, participating membership. Financial participation isn't the only aspect. Good members not only pay dues, but they also get involved in the affairs of medicine. This type of concerned member holds the key to our success in the future. ◄

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Comprehensive Health Planning-Partnership for Health

(One of a series prepared by Blue Shield)

A program of considerable interest to all involved in every aspect of the health field is Comprehensive Health Planning. And, as the legislation passed in 1966, PL89-749, and its amendments of 1967, PL90-174, states, "total comprehensive planning must begin, and continue, in order to better utilize and deliver the varying services dealing with the health of all America. From environmental problems of health to the hospital, nurse and physician, all resources should be used to coordinate these services where there are problems."

To accomplish the above goal, Comprehensive Health Planning was brought into being to encourage the local community to look at itself and seek out problem areas. And, in turn, to cooperate with other communities around them for problem areas on a larger scale.

The Amendments of 1967 were labeled the "Partnership for Health Amendments," and this is exactly what is entailed. A partnership of all aspects of the community . . . a partnership of all communities . . . a partnership of all aspects of the health field.

Realizing the importance of the program and physician participation, the Indiana State Medical Association and Blue Shield began in December of 1968 a cooperative effort to inform the physicians throughout the state about Comprehensive Health Planning. Hank Kiszla, Gary Miller, Fritz Harbridge and Jerry Martin from Blue Shield, were loaned to ISMA over a two-year period to aid in contacting all who were interested.

To date, every County Medical Society has been contacted and we met with all those indicating any interest. Much of the state is now in some phase of organization into planning groups. Partnership in health . . . another effort by Blue Shield to work with the physicians of Indiana. ◄





ABSTRACTS, BOOK REVIEWS

MEDICAL INTERVIEWING—A PROGRAM MANUAL

Robert E. Froelich, M.D., and F. Marian Bishop, Ph.D., M.S.P.H., by C.V. Mosby Co., St. Louis, 1969, 116 pp., $4.75 (paperbound).

This book develops history-taking skills. Medical students should value this book highly and practicing physicians can learn from it also. The book points out that the M.D. degree does not grant instantaneous interviewing or communicating skills—these must be developed.

In part one, *Medical Interviewing* discusses preparation for the interview, initiation of an interview, assisting the patient's narration, obtaining specific information, structuring the interview, specific interview problems and closing the interview.

Part two takes the reader through seven examples.

The book is structured in the programmed learning method which is becoming so popular.

An assist to attain or return to good history-taking techniques.

ALVIN J. HALEY, M.D.
Fort Wayne

CELLULOSE ACETATE ELECTROPHORESIS

H. P. Chin—Ann Arbor-Humphrey Science Publishers, Inc., Ann Arbor, Mich. 48106. 1970, $15.75; 139 pages, 8 tables and 21 illustrations; 536 references.

This very thin volume is a stunning surprise! The author is crisply clear; he is almost deceptively simple. He tells the medical student and the average M.D. just what *is* and *why* in a developing frontier of medicine that has been baffling the finest of teachers.

The reader has spelled out for him the very bare bones of the subject in a manner that is an absolute delight! Incidentally, he throws in much material that is most interesting even if not totally germane to the issues at hand. I was titillated by being told that protein electrophoresis now can identify the precise fish that is being used in fish meal; the commercial product can be monitored in making sure that the consumer gets what the label says is there.

The format is excellent; the binding, printing and paper superb in every way. The seemingly high price is really low considering the bargain being given the reader.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

STUDIES OF PSEUDOHYPERTROPHIC MUSCULAR DYSTROPHY

Charles A. Bonset, M.D.; Charles C Thomas, Springfield, Ill., 1969, 159 Ed. (American Lecture Series).

Here is a well-written little book by an Indiana author which presents all there is to know about muscular dystrophy. If you have one of these unfortunate patients in practice, read this book.

Dr. Bonset divides the book into two parts—the first presents history, research philosophy, and describes four clinical patterns of muscular dystrophy; the second part studies muscular dystrophy from a basic science standpoint.

ALVIN J. HALEY, M.D.
Fort Wayne

CALCITONIN—PROCEEDINGS OF THE SECOND INTERNATIONAL SYMPOSIUM, 1969

Springer-Verlag, N.Y., 1969, 568 pages, illustrated, $24.80. edited by S. Taylor and G. Foster, cloth, published July 1970.

Until 1962, we thought that the parathyroids secreted parathyroid hormone: this being responsible for maintaining proper calcium serum levels. In 1962, *calcitonin* was uncovered in the secretions of the *ultimobranchial* gland; frankly, this was my first inkling of the very existence of this all but occult structure!

In the mere half dozen years since, calcitonin has been analyzed and synthesized. The different varieties of the hormone—bovine, human, porcine and what have you—have been explored for action and potencies. The compounds have been analyzed and synthesized. We have learned that this substance increases absorption of calcium from the gut and promotes bone resorption thus preventing hypercalcemia and excessive bone destruction.

The details spelled out by the members of this symposium are grist for the experts. The M.D. would do well to learn of the existence of this hormone. He might even ponder the brand new fact that we have a new laboratory test for medullary carcinoma of the thyroid. A sudden rise in the serum level of calcitonin presages the presence of the neoplasm long before there is any other overt evidence of any sort . . . .

The binding is excellent. There are quite a few trifling typo errors. I LIKED the book.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

INTRODUCTION TO PROTOZOOLOGY

Reginald D. Manwell—Dover Publications, N.Y. 1969, paperback, $4.00, 642 pages, innumerable figures (two in color).

Incredibly enough, we are furnished at a nominal price a very creditable textbook of just what it claims to be: 'Introduction to Protozoology'. As a college freshman, I was taught the rudiments of the topic from just such a text. Then: along came the medical school. I was now trained to look at the protozoa *parasitic* to Man. I acquired a very great respect for the plasmodia of malaria. By the way, the color plates facing the front and back pages of this volume illustrate their life cycles and are (all by themselves) worth the modest price of this book.

The words "parasitism" and "symbiosis" acquired greater meanings to me. "Trichomonas", "spirochetes", "entameba", etc., etc. came to be associated with very specific and definitive diseases. It is good to pick up a volume and go back to the days of elementary zoology. Somehow or other, I do think that a greater perspective is acquired.

The binding, printing and typography are most satisfyingly excellent. It is a pleasure to approve a volume in so total a manner.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

BIG FLEAS HAVE LITTLE FLEAS OR WHO'S WHO AMONG THE PROTOZOA

Robert Hegner—with a new introduction by Reginald D. Manuell—paperback edition (1968) by Dover Publications, Inc., N.Y., $2.00.

This lovely little book is a nostalgic reminder of a splendid teacher who died while in his prime during WWII. The paper and binding are superb. The little original illustrations remain as sketched by Prof. Hegner; the chapter closing poetic chortles—ah! don't forget to savor eaeh and every one of them.

Of eourse, protozoology has aequired a good deal of additional knowledge in the nigh 30 years since these lines were first being formulated. This in no way diminishes the readability of what the student is viewing.

This little volume should suit every purehaser—from the lowliest high school sophomore to the most sophisticated M.D. Thanks again, Dover Publications.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

COMBINED TREATMENT OF PARKINSONISM WTH L-DOPA AND AMANTADINE

R. B. Godwin-Austen et al. (National Hosp. for Nervous Diseases, London)

Lancet 2:383-385 (Aug. 22) 1970.

A double-blind crossover trial of combined treatment with amantadine and L-dopa was conducted in 24 patients with parkinsonism. Twelve were on long-term treatment with L-dopa, and amantadine was added to their treatment, while 12 had L-dopa added to their long-term treatment with amantadine. Further benefit was shown in the group in whom amantadine treatment was supplemented by L-dopa, whereas no additional benefit was detected in patients on optimal L-dopa therapy when amantadine was added. Combined treatment with these drugs is only indicated when the maximum tolerated dose of L-dopa is very small.

CHROMOSOME BREAKAGE IN HUMANS EXPOSED TO METHYL MERCURY THROUGH FISH CONSUMPTION

S. Skerfving, K. Hansson and J. Lindsten (National Institute of Publie Health, Stoekholm)

Arch. Environ. Health 21:133-139 (Aug.) 1970.

Chromosome analysis was performed on cells from lymphoeyte eultures from nine subjects with increased levels of mercury in their red blood eells and in four healthy controls. The elevated mercury levels probably originated from dietary fish with high levels of methyl mercury. A statistically significant rank correlation was found between the frequency of cells with chromosome breaks and mereury concentration. The biological significance of these findings is at present unknown.

THYROIDECTOMY FOR HYPERTHYROIDISM

W. R. Olsen, R. H. Nishiyama, and L. W. Graber (Univ. of Miehigan Medical Center, Ann Arbor)

Arch. Surg. 101:175-180 (Aug.) 1970.

Postoperative thyroid function was determined in 285 patients who had thyroidectomy for hyperthyroidism, and the results correlated with the amount of lymphocytic infiltration of the surgical specimen. Complications of total and subtotal thyroidectomy were recorded. Twenty-five percent of the patients followed more than two years after subtotal thyroideetomy developed hypothyroidism, and 7% developed recurrent hyperthyroidism. Although hyperthyroidism usually developed in the late postoperative period, 96% of those patients who developed hypothyroidism did so within two years postoperatively. Marked lymphocytie infiltration of the thyroid gland has some statistical correlation with the later development of hypothyroidism but cannot be used to predict postoperative thyroid funetion. Both subtotal thyroidectomy and total thyroidectomy are safe and effective. Because of the higher risk of complications after repeat thyroideetomy, insulin I 131 is advised for recurrent hyperthyroidism.

SEPTICEMIA AND PULMONARY EMBOLISM COMPLICATING USE OF ARTERIOVENOUS FISTULA IN MAINTENANCE HEMODIALYSIS

J. Levi, M. Robson and J. B. Rosenfeld (Renal Unit, Beilinson Medical Center, Tel-Aviv Univ. Medical School, Israel)

Lancet 2:288-289 (Aug. 8) 1970.

Seven cases of septicemia in six patients with internal arteriovenous fistulae and undergoing maintenance hemodialysis are described. Two of these patients had pulmonary embolisms, the clinical picture being confirmed by serial chest x-rays. There was no connection between gross evidence of local infections and the development of septicemia or pulmonary embolism. In contradistinction with the cases with external shunts, where septicemia and pulmonary embolisms were treated by removal of the shunt, in cases with arteriovenous fistula, antibiotic treatment is usually sufficient, and only in one case was closure of the fistula required.

THYROID AS ADJUVANT TO AMPHETAMINE THERAPY OF OBESITY: CONTROLLED DOUBLE-BLIND STUDY

N. M. Kaplan and A. Jose (Univ. of Texas Southwestern Medical School, Dallas 75235)

Amer. J. Med. Sci. 260:105-111 (Aug.) 1970.

Despite valid criticism against the indiscriminate use of various drugs in the treatment of obesity, little scientifie evidence is available concerning the value of relatively small amounts of thyroid hormone. Therefore, the effects of the addition of three grains of desiccated thyroid to 15 mg of a sustained-release preparation of dextroamphetamine sulfate were examined in 101 obese patients in a controlled, double-blind study. This addition produced a greater weight loss than amphetamine alone, which, though slight, was statistically significant, without any clinical feature of thyroid hormone exeess. On the basis of experimental evidenee, the increased weight loss is interpreted as a pharmacologic effect of a slightly greater than physiologic dose of thyroid hormone.

ANIMAL SOURCES OF COMMON SEROTYPES OF *ESCHERICHIA COLI* IN FOOD OF HOSPITAL PATIENTS

R. A. Shooter et. al. (St. Bartholomew's Hosp., London)

Lancet 2:226-228 (Aug. 1) 1970.

The hospital food, the hospital kitchen, the meat on arrival in the hospital, and the meat and the environment in an abattoir and a poultry packing station have been examined for the presence of *Escherichia coli*. Large numbers of the organisms were found in all these situations. This constitutes a route by which strains of *E coli* from animals reach the human population. Administration of antibiotics to animals may be followed by the establishment of antibiotic-resistant strains of *E coli* in the human bowel, with the subsequent appearance of urinary tract infections which are more difficult to treat.

CHROMOSOME STUDIES IN SELECTED SPONTANEOUS ABORTIONS: I. CONCEPTION AFTER ORAL CONTRACEPTIVES

D. H. Carr (Dept. of Anatomy, McMaster Univ., Hamilton, Ontario)

Canad. Med. Assoc. J. 103:343-348 (Aug. 15) 1970.

During the past seven years the authors studied the chromosomes of human spontaneous abortuses. A control and unselected series was compared with findings in 54 abortuses from women who conceived within six months of discontinuing oral contraceptives. It was found that polyploidy (triploidy and tetraploidy) was increased in the post-oral contraceptive group when compared with controls. Polyploidy almost always leads to early abortion. The chromosome anomalies which are compatible with live birth (trisomy and x-monosomy) are not increased in abortuses from women who recently discontinued oral contraceptives. The increase in polyploidy in these circumstances may be related to temporary hormonal imbalance.

HYPERSENSITIVITY PNEUMONITIS DUE TO CONTAMINATION OF AIR-CONDITIONER

E. F. Banaszak, W. H. Thiede, and J. N. Fink (Marquette Univ. School of Medicine, Milwaukee)

New Eng. J. Med. 283:271-276 (Aug. 6) 1970.

Four of 27 office workers developed symptoms of intermittent chills, fever, and dyspnea, or progressive dyspnea alone. Pulmonary function studies indicated restrictive and diffusion defects and x-ray examination demonstrated diffuse nodular infiltrates in all four patients. Examination of their environment revealed contamination of the air conditioning system with a thermophilic actinomycete known to cause a hypersensitivity pneumonitis such as farmer's lung. Sera of all affected individuals contained high titers of rheumatoid factor and precipitating antibodies against the offending organism. Insufflation of one of the ill workers during an asymptomatic period reproduced all clinical features of the disorder. Treatment with steroids and avoidance of exposure resulted in recovery.

NEWSPAPER INFLUENCE ON SUICIDE

J. A. Motto (Univ. of Calif. School of Medicine, San Francisco)

Arch. Gen. Psychiat. 23:143-148 (Aug.) 1970.

To further develop the contention that newspaper reports of suicidal behavior precipitate suicide among suggestible readers, the suicide rate during a 268-day newspaper strike in a major metropolitan area was compared with the mean rate for the same period of the previous four years, and the subsequent year. A comparison of combined age- and sex-specific groups showed that the newspaper blackout was accompanied by a significant decrease of the suicide rate among women under 35. Implications and questions raised by these findings are discussed with special concern for the broader role played by the press in influencing the developing value system of receptive readers.

LICENSING THE DRIVER WITH ALTERATIONS OF CONSCIOUSNESS

M. S. Stock et al. (Environmental Control Administration, Cincinnati 45312)

Arch. Neurol. 23:210-211 (Sept.) 1970.

Criteria for licensing drivers who have alterations of their state of consciousness have been set up by the US Public Health Service to aid state medical advisory boards in their evaluation of these drivers. Those drivers who have not had an episode within three years may drive passenger transport, cargo transport, and private vehicles. Those who have had an episode within three years but not within one year may drive private vehicles only, and those who have had an episode within one year may not drive at all. These criteria should help standardize and make uniform the guidelines throughout the states for evaluating and licensing the impaired driver.

PSYCHOSIS AND OTHER PSYCHIATRIC MANIFESTATIONS OF LEVODOPA THERAPY

G. G. Celesia and A. N. Barr (1954 E. Washington Ave., Madison, Wis. 53704)

Arch. Neurol. 23:193-200 (Sept.) 1970.

Sixteen of 45 patients receiving levodopa developed psychiatric phenomena, including psychosis, acute anxiety, and euphoria. Fourteen of the 16 (87.5%) had associated buccolingual or generalized dyskinesia, which is characteristic of levodopa toxicity. The levodopa psychosis-dyskinesia complex is reversible and most frequently controlled by diminution of levodopa dosage. It occurs mostly in patients with associated organic brain syndrome or in those suffering from postencephalitic parkinsonism.

MATERNAL VIRUS INFECTION AND CONGENITAL ANOMALIES

G. C. Brown (School of Public Health, Univ. of Michigan, Ann Arbor 48104)

Arch. Environ. Health 21:362-365 (Sept.) 1970.

A continuing prospective study of the incidence of viral infections during pregnancy and their association with congenital malformations is described. Histories of illness during pregnancy are recorded, and blood samples are taken again at delivery. Infants are observed for one year. When anomalies are diagnosed and classified, the maternal sera, together with matched control specimens from mothers of normal infants, are tested for serological evidence of infection with selected viruses. Several viruses appear to be more frequently encountered during pregnancy by mothers of infants with certain types of anomalies. Most strikingly, a statistically greater incidence of infection with type B coxsackieviruses, and especially B3 and B4, was observed in mothers of infants with congenital heart disease than in mothers of normal children.



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From the President's Desk

In assuming the presidency of this professional organization I am mindful of the Association's responsibilities as well as those of my office. Perhaps it would be thought-provoking to review the word "profession."



Medicine, historically, is one of three learned professions—others being law and theology. A profession is a calling that requires specialized knowledge obtained from long academic study—fully known and understood by its members. It develops and maintains a code of ethics for its members by which the professionals may guide their own actions and by which peers and the public can judge their behavior. Members also make significant personal sacrifice in order to join and remain in the profession. The profession is given public trust that is shared by no one else; its members are trusted with information, dreams, fears and inadequacies that are kept secret from the rest of the world. A true profession has as its sole aim service to the public, not to itself, not to those only who receive the service but to all mankind.

Of all of these attributes, service to all mankind should be the keystone of the medical profession. As we study and work towards solving the current "crisis in delivery of health care," we must be ever mindful of public service.

At the June 1970 meeting, the American Medical Association adopted a policy statement which called for "factual investigation and objective experimentation in new methods of delivery of health care, while still maintaining faith and trust in the private practice of medicine and pride in its accomplishments." Our aim to serve the public requires us to recognize that different systems of care may be necessary for different population groups and different geographical areas. But, regardless of the resulting changed "system," we physicians must continue to serve the public with compassion.

I hope in the coming months to stimulate your thinking and your participation in solving our current medical problems. Opportunities are constantly presented—locally, statewide and nationally—for us to be heard and to provide wise leadership. We are a minority that now must be heard. We must prepare ourselves to participate in a way to influence decisions.

M. O. Seamahorn, M.D.

What's New?

Parke-Davis' Medical Instruments Division announces a portable electrocardiograph. The instrument was planned for simplicity of operation and will give satisfactory service in the office, home or hospital. It has solid state circuitry and requires only ten seconds for warmup. It features positive patient protection.

* * *

Technicon has a new automated analytical system for blood chemistry. Called the SMA® 12/Jr., the instrument is offered at rental rates low enough to make profiling available to small hospitals, private laboratories and physicians in group practice who will require as few as 10 clinical chemistry profiles per day.

* * *

A wireless, four-patient cardiac monitor system has been developed by Laser Systems and Electronics for the patient who has been transferred from coronary care or intensive care to the standard care sections of the hospital. The patient wears a miniature telemetry unit slightly smaller than a cigarette pack. A master monitor picks up data from the patient and displays it on an oscilloscope and heart-rate meter. The device may be set with critical heart-rate limits which will actuate a strip chart recorder and alarms.

* * *

Blood chemistry may now be determined on a single drop of blood. Damon Engineering announces a new automated multiple microchemical system which will perform a biochemical profile on one drop—making the process adaptable to infants, children and the aged. The Damon service covers the specimen collectors, preservation of the blood, its analysis and the data presentation.

* * *

Bourns Life Systems has a new model wide Tiltable Infant Bed designed to provide controlled positioning of newborns during intensive care and arranged so that the bed may be tilted from side to side to prevent damage from prolonged pressure. The bed will fit in a standard incubator or isolette. X-rays may be taken without disturbing the child. Two hose adaptors with articulated arms allow freedom of movement when a respirator is necessary.

* * *

Cenco announces availability of packaged kits of items essential for the care of hospital patients. These come in an attractive box which bears the hospital name, in a polyethylene tote bag with handles or in a polybag with tie tapes. Items such as Kleenex, skin lotion, soap, mouthwash, toothpaste, washcloth, and others are suggested. The kits may be tailored to the hospital's specifications.

* * *

A new orthopedic cast material, Lightcast, is announced by Solar Laboratories. Lightcast is a soft, flexible, resin-impregnated fiberglass tape which is wrapped on in the usual manner and is hardened by about five minutes' exposure to a specific wave-length light. The resulting cast is about one-third the weight of plaster. It is radio-transparent —X-rays may be made with fine detail under normal non-cast X-ray settings. The material after it is set allows air circulation and is impervious to water. It may be cut off with ordinary heavy shears. The inventor was inspired by the experience of wearing a plaster of paris leg cast some years ago.

* * *

'Ornex' is a new drug product specifically formulated for the temporary relief of discomfort due to acute and chronic sinusitis which has been introduced by Smith Kline & French. It is a non-prescription product containing caffeine, acetaminophen and salicylamide, useful in aspirin-sensitive patients. It is recommended for working patients since it contains no antihistamines or sedatives. It also contains phenylpropanolamine hydrochloride for decongestant action.

* * *

Posey has a new padded leather hand-restraint cuff. Kodel polyester padding is held in place by Velcro. The padding is removable for laundering. Each cuff comes with a strap with a new friction type keylock buckle which will allow arm movement.

* * *

Damon Corporation has a new microtesting blood service which allows a biochemical profile to be performed on a drop of blood. Their Autolance™ is a sterile disposable device which performs a precise dermal puncture of sufficient size to insure a representative sample of blood. The Damon Microtainer® is a disposable plastic capillary loop which contains the preservatives and serves as a collecting device and also as a transport to the laboratory. The analyzer is modular in nature and is being tested with a profile of 12 tests. It may be expanded to 20 tests later.

* * *

Minkus Publications has a new stamp album—"Medicine on Stamps." The author is Dr. Joseph H. Kler, whose personal collection of stamps of medical significance amounts to 16,000 specimens. The album is loose-leafed and can be added to when future medical stamps are issued. Beneath each illustration in the album is a capsule biography of the physician or medical scientists shown on the stamp.

* * *

The new Parke-Davis German measles vaccine, Rubelogen, has been released for sale. It is recommended for all children between ages of one year and up to adolescence especially those in kindergarten and early elementary grades. Routine immunization of adolescent and adult females is not recommended.

ISMA Organizes Speakers Bureau

Following is a listing of Indiana State Medical Association members who comprise the ISMA Speakers Bureau.

These speakers may be contacted directly by the county or district medical society wishing their services. This also applies to professional or lay organizations who might wish to utilize the Bureau.

For additional information, contact the Headquarters Office, Indiana Sate Medical Association, 3935 N. Meridian St., Indianapolis, Indiana 46208. Telephone (317) 925-7545.

SPEAKERS BUREAU

INDIANA STATE MEDICAL ASSOCIATION

ALCOHOLISM	
Alcohol and Alcoholism	Paul M. Flanagan M.D. 3440 N. Meridian St. Indianapolis 46208
ALLERGY	
Allergy	Julian R. Kaufman, M.D. 3124 East State Blvd. Fort Wayne 46805
BLOOD DISEASES	
Blood Disorders	Laurence H. Bates, M.D. 3524 N. Meridian St. Indianapolis 46208
CANCER	
Pap Smear	William J. Pierce, M.D. Bruceville 47516
Cancer and Leukemia	Laurence H. Bates, M.D. 3524 N. Meridian St. Indianapolis 46208
Gynecologic Cancer—Diagnosis and Management	Hans E. Geisler, M.D. 5470 E. 16th St. Indianapolis 46218
Cancer—Diagnosis and Treatment	H. H. Dunham, M.D. 1025 Manchester Wabash 46992
Cancer, As Seen by a Diagnostic Radiologist	Robert W. Currie, M.D. 512 E. 57th St. Indianapolis 46220
CHILDBIRTH	
Prenatal Classes for Educated Childbirth	Thomas M. Conley, M.D. 500 Southway Blvd., East Kokomo 46901
EYE	
Contact Lenses Glaucoma General Ophthalmology	Martin Fundenberger, M.D. 2815 E. 38th St. Indianapolis 46218
GASTRO-INTESTINAL	
Diseases of the Gastrointestinal Tract, Liver and Pancreas	Stephen R. Stouder, M.D. St. Vincent's Hospital 120 W. Fall Creek Parkway Indianapolis 46208

GENERAL

Medicine, Government, Religion Architecture—Ancient and Modern Rome Sex Dyslexia	Daniel H. Cannon, M.D. 1203 E. Spring St. New Albany 47150
Project Hope	Richard L. Westerman, M.D. Box 10 Zionsville 46077
Common Medical Problems	Raymond J. Doherty, M.D. 47 W. 68th Pl. Merrillville 46410

GENERAL PRACTICE

Family Practice General Practice	Ross L. Egger, M.D. Daleville 47334

HEALTH CAREERS

Allied Health Careers, Opportunities, Educational Programs, Recruitment	J. Lynn Arbogast, M.D. I.U. Medical Center Indianapolis 46202
Medical Careers	M. O. Scamahorn, M.D. Pittsboro 46167

HEART AND BLOOD VESSELS

Diagnosing the Coronary-Prone	William J. Pierce, M.D. Bruceville 47516
Cerebral Vascular Disease	Mark L. Dyken, M.D. I.U. Medical Center Indianapolis 46202
Heart Disease in Children	Donald A. Girod, M.D. I.U. Medical Center Indianapolis 46202
Preventing Coronaries	Raymond J. Doherty, M.D. 47 W. 68th Pl. Merrillville 46410

HISTORY OF MEDICINE

Medicine in Central Indiana, Rural 19th Century	M. O. Scamahorn, M.D. Pittsboro 46167

MEDICAL EDUCATION

Medical Education	Stephen R. Stouder, M.D. St. Vincent's Hospital 120 W. Fall Creek Parkway Indianapolis 46208
Graduate Training in Community Hospitals	Ross L. Egger, M.D. Daleville 47334
Medical Education	Joseph M. Black, M.D. 502 W. Second St. Seymour 47274

MEDICAL — LEGAL

Malpractice Medical Efficiency Professional Corporations Taxes	Walter Able, M.D. 2760 25th St. Columbus 47201

MEDICAL ORGANIZATION

Medical Organization	B. E. Kintner, M.D. 236 Simpson St. Elkhart 46514
General Area of Organized Medicine, Medical Education and Other Subjects	Peter R. Petrich, M.D. 401 S. Perry St. Attica 47918
Organized Medicine	Eugene S. Rifner, M.D. Van Buren 46991

MEDICAL TEACHING

Medical Teaching Interdenominational Christian Medical Center, Vellore, India	Naomi L. Dalton, M.D. 2307 E. Second St. Bloomington 47401

MENTAL HEALTH

Mental Health	B. E. Kintner, M.D. 236 Simpson St. Elkhart 46514

NEUROLOGY

Multiple Sclerosis Diseases of Muscle and Peripheral Nerves	Mark L. Dyken, M.D. I.U. Medical Center Indianapolis 46202

NUTRITION

Selected Topics in Pharmacology Nutrition	Richard L. Westerman, M.D. Box 10 Zionsville 46077

ORTHOPEDICS

Club Foot Heredity of Musculoskeletal Disorders Childrens' Orthopedics	Robert Palmer, M.D. 1255 W. 86th St. Greenbriar Professional Bldg. Indianapolis 46260
Orthopedic Subjects	Lee Cattell, M.D. 400 S. Berkley Rd. Kokomo 46901

POPULATION CONTROL

Population Control Problems	Thomas M. Conley, M.D. 500 Southway Blvd., E. Kokomo 46901
Mental Retardation and Voluntary Sterilization Population Control and Public Health Voluntary Sterilization and Family Planning	Herschel C. Moss, M.D. 1640 N. Ritter Ave. Indianapolis 46218

PREVENTIVE MEDICINE

Preventive Medicine Health Hazard Appraisal	Lewis C. Robbins, M.D. 1815 N. Capitol Ave., #302 Indianapolis 46202
Preventive Medicine Annual Physical Examinations	Frederic L. Schoen, M.D. 5717 S. Anthony Blvd. Fort Wayne 46806

PSYCHOLOGY

The Psychological Development of Children	Raymond J. Doherty, M.D. 47 W. 68th Pl. Merrillville 46410

PUBLIC HEALTH	
Air Pollution	Julian R. Kaufman, M.D. 3124 E. State Blvd. Fort Wayne 46805
Public Health	Joseph M. Black, M.D. 502 W. Second St. Seymour 47274
PUBLIC RELATIONS	
Public Relations	B. E. Kintner, M.D. 236 Simpson St. Elkhart 46514
What Lay People Should Know About Medicine	Louis F. Bradley, M.D. 303 S. Main St. Bluffton 46714
RADIOLOGY	
Diagnostic Radiology Radiology Technology	Henry H. Dunham, M.D. 1025 Manchester Wabash 46992
RELIGION	
Religion and Medicine	B. E. Kintner, M.D. 236 Simpson St. Elkhart 46514
REPRODUCTION	
Reproductive Education	Thomas M. Conley, M.D. 500 Southway Blvd., E. Kokomo 46901
SEX EDUCATION	
Sex Education	Raymond J. Doherty, M.D. 47 W. 68th Pl. Merrillville 46410
SKIN (DERMATOLOGY)	
Diseases of the Skin Tumors of the Skin	James H. Gosman, M.D. 1815 N. Capitol Ave. Indianapolis 46202
SMOKING	
Smoking and Health	Robert W. Currie, M.D. 512 E. 57th St. Indianapolis 46220
SOCIO-ECONOMIC-POLITICAL	
Medical Socio-Economics	B. E. Kintner, M.D. 236 Simpson St. Elkhart 46514
Office Practice	Frederic L. Schoen, M.D. 5717 S. Anthony Blvd. Fort Wayne 46806
Socio-Economics	Donald R. Taylor, M.D. Ball Memorial Hospital Muncie 47303
The State Legislature and Medical-Governmental Problems General Problems of State of Indiana-Education, Taxes, Roads and Highway Safety; Constitutional Amendments	Otis R. Bowen, M.D. 304 N. Center St. Bremen 46506

Politics and Medicine	B. E. Kintner, M.D. 236 Simpson St. Elkhart 46514
Legislation Medical Socio-Economics Medical Insurance Welfare	Joseph M. Black, M.D. 502 W. Second St. Seymour 47274

SPORTS AND MEDICINE

Sports and Medicine	Thomas A. Brady, M.D. 1815 N. Capitol Ave. Indianapolis 46202

SURGERY

Vascular Surgery	Austin L. Gardner, M.D. 3266 N. Meridian St. Indianapolis 46208
General and Vascular Surgery	Jack L. Kelley, M.D. 2600 Greenbush St. Lafayette 47904

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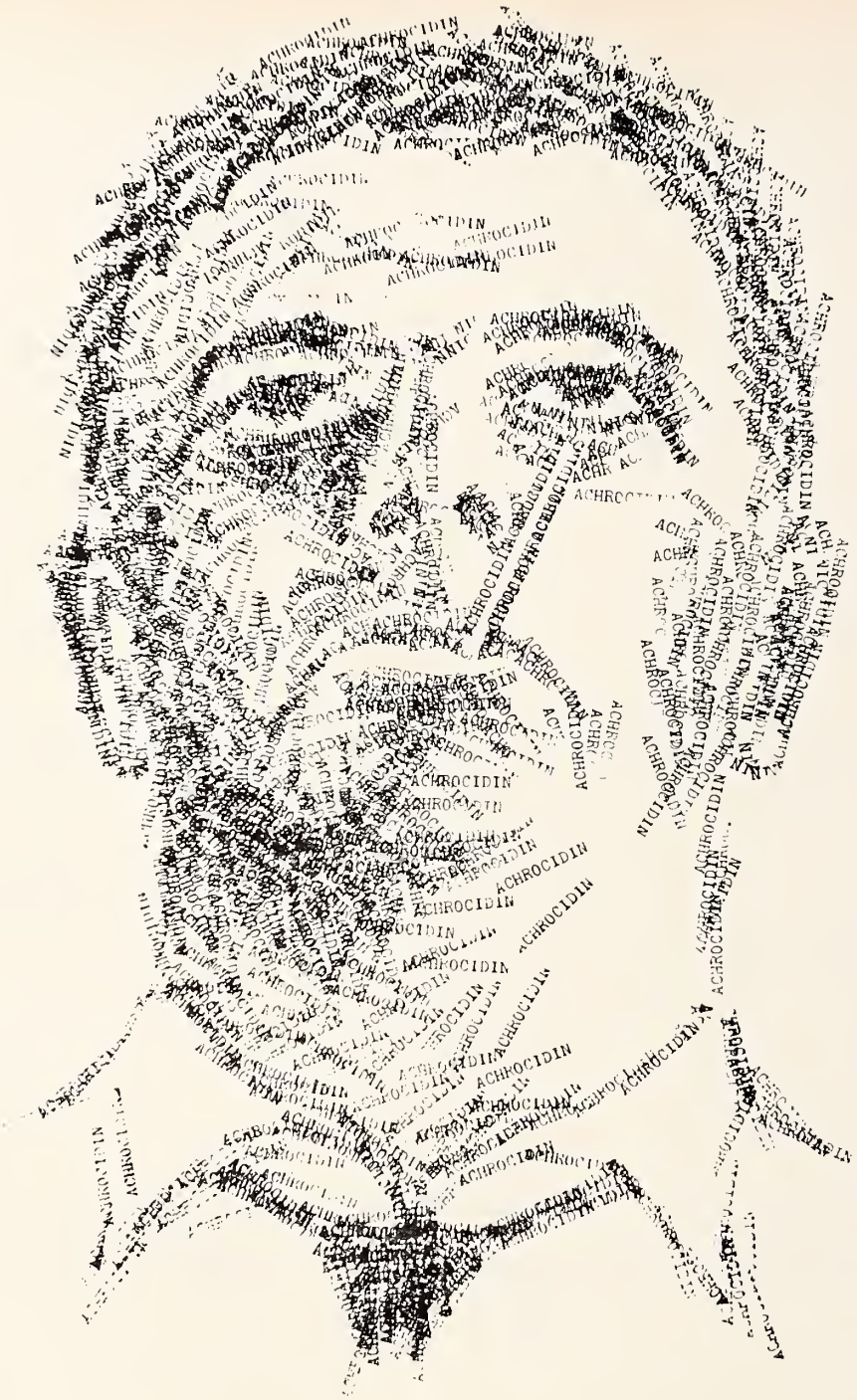
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Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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Dr. Malcolm Scamahorn Succeeds to Presidency

Dr. Malcolm Scamahorn succeeded to the presidency of the Indiana State Medical Association during the Annual Convention in South Bend. At that time he had just completed a busy year as president-elect, and before that he had completed a series of busy years. During his professional life he has occupied practically every office that medicine can bestow within the state.

Dr. Scamahorn was graduated from Indiana University with the M.D. degree in 1943. He had his internship at the Methodist Hospital in Indianapolis and also served two residencies, one in obstetrics and gynecology and the other in medicine, at the same hospital.

Following service as a medical officer in the U. S. Army for two years he entered general practice in his home town of Pittsboro, an activity which continues to the present time.

Dr. Scamahorn has been secretary and president of the Hendricks County Medical Society and president of the 7th District Society. In addition to serving as delegate to ISMA, he has been a member of and for many years the chairman of the Committee on State Fair. He was chairman of the Commission on Special Activities for many years and has also worked on the Commission on Legislation.

He was chosen as assistant treasurer of ISMA in 1967 and as president-elect in 1969.

Dr. Scamahorn is well known also for his many community activities and for his dedicated work as a member of the medical staff of the Hendricks County Hospital. His contributions to the preceptorship program of Indiana University School of Medicine and his participation in the GP Club, in fact his interest in and sponsorship of the cause of general practice in general, is widely recognized and highly appreciated. He enters the presidency of our Association with a wealth of experience and a fine record of achievement.

Hypertension Program Presented at Evansville

Drs. Walter E. Judson and Jack H. Hall, Indianapolis, presented a program on hypertension at St. Mary's Hospital, Evansville, on November 4. "Diagnosis of Renovascular Hypertension" was Dr. Judson's subject, while Dr. Hall spoke on "Treatment of Hypertension." The program, which was acceptable for two prescribed hours by the American Academy of General Practice, was presented by the Department of Medical Education, St. Mary's Hospital, the Vanderburgh County Heart Association and the Indiana Heart Association, Inc.

American College of Surgeons Inducts 26 from Indiana

More than 1500 surgeons were inducted as Fellows by the American College of Surgeons at its Clinical Congress in October. Those from Indiana are as follows:

East Chicago: Ara V. Dumanian.

Edinburg: Francisco D. Deogracias.

Evansville: Bryant A. Bloss, John E. Heumann.

Fort Wayne: Perry A. Brucker, Thomas L. Herendeen, Jack W. Patterson and Alfred A. Wick.

Hammond: David M. Harvey, Harvey J. Levin.

Indianapolis: John E. Joyner, Stafford W. Pile, Jr., Ansel W. Schmalhansen and H. Marshall Trusler.

Kokomo: Thomas R. Scherschel.

Lafayette: Don C. Fields, Jack L. Kelley

Marion: Herbert C. Khalouf, Marcene Pearcy.

Muncie: Howard R. Searight.

Munster: Mario D. Mansueto.

New Castle: Paul T. Kinkade.

Richmond: George S. Porter.

Valparaiso: Daniel R. Evans, Alfred J. Kobak, Jr., and Cyrus Moayad.

AEC Offers Booklets

The Atomic Energy Commission has a new series of booklets for junior high school students explaining nuclear energy and its uses. Already published are "Atomic Pioneers" and "The Mysterious Box: Nuclear Science and Art." Other booklets will follow. Single copies of the two booklets may be obtained without charge by addressing the Commission, Att: Technical Information, P.O. Box 62, Oak Ridge, Tennesee 37830.

Speaks at Graduation Exercises

Dr. Alexander S. Williams, Gary physician and Lake County coroner, was the speaker at graduation exercises on October 11 for the Practical Nurse Training Program at the Purdue University Calumet Campus. Twenty-eight women from northern Indiana were members of the 44th class to earn practical nurse certificates since the non-collegiate training course began at the campus in Hammond in the 1950's.

Wyeth Offers Two Prize Winning Films

Wyeth Laboratories received two awards in the 12th annual American Film Festival for two medically oriented educational films. "Happy Family Planning" received a blue ribbon in the category "Health for General Audience." It is an eight-minute, color film with music. It is made in 16 mm. and 8 mm. It is designed for lay groups and reviews various contraceptive methods. It is available on loan through Wyeth representatives or by writing Wyeth Film Library, P.O. Box 8299, Philadelphia 19101. "Case in Point" won the red ribbon in the "Vocational Guidance" category. It is a 25-minute, 16 mm. color film which outlines precautions by which the medical assistant and her physician-employer can help protect themselves from lawsuits. It is available for showing to physicians or their assistants by contacting the Wyeth representative or writing the Film Library at the address above.

Dr. Carlberg Returns After Service With MEDICO

After serving the month of September in Honduras as a vol-

unteer with MEDICO, a service of CARE, **Dr. Dale L. Carlberg** has returned to his practice in Jeffersonville.

MEDICO has teams of physicians, nurses, physical therapists and technicians serving at installations on three continents. In addition, visiting doctors volunteer their services, paying their own travel expenses on month-long tours to augment the work of the regular teams.

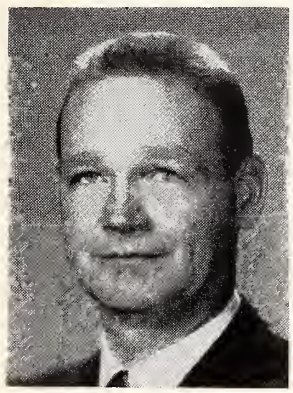
Fourteen to Speak On Cancer Chemotherapy

Mead Johnson Laboratories will sponsor a Cancer Chemotherapy Program in 1971. The program will consist of lectures to be given by outstanding medical authorities in the field of Cancer Chemotherapy. Fourteen M.D.'s, all with hospital, university or clinic affiliations, will deliver the lectures.

Medical organizations interested in obtaining one of the speakers should contact: Martin E. Vancil, M.D., Associate Director, Medical Research Department, Mead Johnson & Company, Evansville, Indiana 47721.

Mead Johnson Laboratories will make arrangements for speaker procurement and will defray expenses for honoraria, travel and lodging.

Dr. Walther Assumes College Presidency



Dr. Joseph E. Walther, Indianapolis, assumed the presidency of the American College of Gastroenterology on October 26. He has been a governor or a trustee of the College since 1955 and has just completed a year as president-elect.

"Stop Smoking" Recording Available

A new recording is now available to habitual smokers who wish to stop. It incorporates a form of hypnosis described as receptive concentration used by psychiatrist Dr. Herbert Spiegel, noted for his single treatment "cure" of one out of five hardcore smokers. Dr. Spiegel is an Associate Clinical Professor of Psychiatry at Columbia University.

The recording uses the same technique as the actual 45-minute person-to-person session with Dr. Spiegel. At a recent seminar at the American Psychiatric Association meeting in San Francisco, Dr. Spiegel demonstrated his technic which he pointed out is "directed to the many people who know the danger of smoking . . . who want to stop smoking. . . who have tried and failed." "Stop Smoking," a 33⅓ rpm high-fidelity recording is produced by Media Medica, Inc., a health education organization, and can be obtained by writing directly to them at 555 Fifth Avenue, New York 10017. The price of the record is $5.95 plus handling charges and applicable sales tax, if any.

Named Honorary Chairman

Dr. Edwin B. Bailey, chief of staff of Freeman Greene County Hospital, will serve as honorary chairman for the 1970 Christmas Seal Campaign in Greene County.

Sports Bibliography Offered

The American Academy of Orthopaedic Surgeons has published a listing of more than 1300 article and publication references on sports medicine. The 96-page volume catalogs the literature for physicians and others handling athletes and athletic programs. "A Bibliography of Sports Medicine" may be obtained at $2.00 per copy by writing the Academy at 430 N. Michigan Ave., Chicago 60611.

Three Medical Science Lectures Announced

The AMA program of Lectures in Medical Sciences will be continued this academic year. Dr. Clarance Cohn, Michael Reese Hospital, will talk on "Circadian Rhythms" at Ball State on February 9 and at Earlham on February 10. Dr. Laurence Hursh, University of Illinois, will speak on "Hearts and Fats" at Indiana State on December 9. Dr. Richard Jones, Pritzker School of Medicine, will speak on "The Way to a Man's Heart" at Saint Mary's College in Notre Dame on February 2.

On LaLeche League Program

Drs. R. M. Cassim and Ervin W. Heiser, took part in a panel discussion on childbirth and breastfeeding at a recent meeting of the Elkhart LaLeche League.

Tranquilizer for Treatment of Alcoholism Introduced

Sandoz Pharmaceuticals has introduced a new tranquilizer, Serentil® (mesoridazine), which has special qualities which recommend it for the treatment of alcoholism. It is described as relieving the anxiety, tension and depression which may precipitate alcohol abuse. Sandoz has supported the Rutgers University Center of Alcohol Studies and offers interested physicians a series of recorded panel discussions pertaining to alcohol dependence and its treatment.

Dr. Martin Speaks at Corydon

A series of three programs held at the Old Capitol United Methodist Church in Corydon was addressed by **Dr. Samuel W. Martin, Corydon,** in October. Dr. Martin spoke to the group on sex, drugs and alcohol on three successive Sunday evenings.

American College of Physicians Self-Assessment Program Available

A new opportunity for physicians to assess their own medical knowledge has been announced by The American College of Physicians (ACP).

The College's Second Medical Knowledge Self-Assessment Program, consisting of 700 questions in nine different areas of general medicine, will be made available to all physicians—whether or not they are members of the medical specialty organization.

More than 12,000 physicians participated in the ACP's first Self-Assessment Program which was offered in 1968.

To take part in the 1971 Program, physicians who have not received a prospectus may obtain one by writing The American College of Physicians, Box MKSAP-II, 4200 Pine Street, Philadelphia, Pa. 19104. Cost of participation is $20.00 for ACP members, $40.00 for non-members.

Elected to Cancer Board

Dr. Allen S. Martin, Shipshewana, was named to the board of directors of the LaGrange County Cancer Society. He succeeded **Dr. Dean Mattox, Howe.**

AAGP to Become AAFP

The American Academy of General Practice is in the process of changing its name to the American Academy of Family Physicians. The change in constitution was approved by the Academy's Congress of Delegates at their recent meeting. It will become official when the same body validates the action, as is confidently expected, at its meeting in 1971. The delegates approved use of the new name in appropriate situations during the interim.

Addresses Women's Conference

Dr. Otto D. Klassen, Elkhart, spoke at the 13th annual Conference for Women at the Oaklawn Psychiatric Center in October.

Addresses Alcoholism Council

Dr. Grant E. Metealfe, South Bend, and Dr. D. Logan Dunlap, president of the St. Joseph County Medical Society, took part in a panel discussion at a recent meeting of the Alcoholism Council at South Bend on October 7.

Attends NSSL Meeting

State Representative **Floyd B. Coleman, M.D.,** of Waterloo, attended the Sixth Annual Meeting of the National Society of State Legislators at Indianapolis from September 30 to October 2.

Attends Scientific Assembly

Dr. Richard W. Wagner, Huntington, attended the Annual Scientific Assembly of the American Academy of General Practice in San Francisco recently.

Larue Carter Hospital Hosts National Exams

The American Board of Psychiatry and Neurology held examinations for certification in child psychiatry recently at Larue Carter Hospital. Eighty examiners were in Indianapolis to examine about 100 candidates, **Dr. Donald F. Moore,** medical director, said.

Address Rural Health Seminar

Drs. Joseph M. Black, Seymour, and Dr. Franklin A. Bryan, Fort Wayne, were among the participants in a seminar on rural health at Indianapolis recently.

Dr. Tyler Appointed Assistant Dean at IU

Dr. Edward A. Tyler, professor of psychiatry, has been appointed Assistant Dean for Student Affairs at the Indiana University School of Medicine.

Returns from Africa

Dr. George Wagoner of Delphi, Mrs. Wagoner, and three friends have returned from a two weeks' trip to Africa. Dr. Wagoner attended medical seminars in Morocco, Kenya and Tunisia.

Dr. Petrich Named President-Elect



Dr. Peter R. Petrich, Attica, was named president-elect of the Indiana State Medical Association at its 121st annual convention at South Bend in October. A 1953 graduate of the Indiana University School of Medicine, he has been in general practice at Attica since 1954.

His servcie at the county and state level began in 1958 when he was elected president of the Fountain-Warren County Medical Society. He has served as delegate, councilor, as a member of the Commission on Medical Education and Licensure and, for the past year, as chairman of the Board of Trustees.

Dr. John Freed Appointed

Dr. John E. Freed, Jr., Terre Haute, has been appointed to that city's Board of Redevelopment.

On Drug Abuse Panel

A panel discussion on drug abuse was presented at the October 8 meeting of the Elkhart North Side Junior High School PTA. **Dr. D. F. Rupell** of the Oaklawn Psychiatric Center was on the panel with the head of the juvenile division of the Elkhart police department and the coordinator of drug abuse education in Elkhart community schools. ◄



HANGER PROSTHESES OFFERS BOOKLET ON AMPUTATIONS

This booklet has been designed for those physicians whose practice includes amputation. Limb Prosthetics gives ready reference for each site of amputation as well as the prostheses recommended for each site.

Over 100 years of experience gained by the Hanger organization have gone into this carefully illustrated booklet. Illustrations include amputation sites for the leg and the arm, various Hanger prostheses and methods of suspension, post-operative care and preparation for prosthesis, plus selected photographs showing the child amputee and training for the above-knee patient.

We believe that you will find Limb Prosthetics a most useful booklet and a valuable source of quick information. To obtain your copy, please write or phone the Hanger office nearest you.

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416 N. Main Street, Evansville, Indiana 47711
3004 S. Wayne Ave., Fort Wayne, Ind. 46807

Continuing Education For Physicians

POSTGRADUATE COURSES IN INDIANA

Obstetrics and Gynecology

November 30—December 1, 1970 — Indianapolis

The first day of this two-day course centers on Obstetrics and Perinatology; specific topics include: intrauterine growth retardation, newer technics for assessment of fetal maturity and management of high-risk pregnancies. Guest speakers: Dr. Thomas K. Oliver, Jr., Chairman, Department of Pediatrics, University of Pittsburgh; Dr. Edgar Makowski, Professor, Department of Obstetrics-Gynecology, University of Colorado. Dr. Robert Cleary, Associate Professor, Department of Obstetrics-Gynecology, Indiana University School of Medicine, will also speak.

The second day attention turns to Gynecological Malignancies and Surgical Problems. Guest speakers: Dr. James Merrill, Chairman, Department of Obstetrics-Gynecology, University of Oklahoma; Dr. J. W. Roddick, Jr., Professor, Department of Obstetrics-Gynecology, University of Kentucky. Dr. Paul Morrow, Assistant Professor, Department of Obstetrics-Gynecology, Indiana University School of Medicine, will also speak.

Common Neurological Problems

December 16, 1970 — Indianapolis

This course outlines basic principles of management of the neurological patient. The morning session is devoted to common neurological symptoms and signs: headache, dizziness, paresthesias, gait disturbances and mental symptoms. The afternoon session turns to management of dyslexia, epilepsy, parkinsonism and cerebrovascular disease.

Depressive Equivalents in Adolescents

January 6, 1971 — Richmond

Combining lecture and clinical demonstration, this course covers certain unique problems presented by adolescent patients seen in general medical practice. Live and taped illustrations will review special interviewing techniques, the adolescent identity crisis, the maintenance of therapeutically effective relationships with the adolescent and his parents simultaneously and the rehabilitation of adolescents with chronic disabilities.

Recent Advances in Clinical Pediatrics

January 6, 1971 — Indianapolis

This postgraduate course covers recent advances in Pediatrics, emphasizing the clinical application of new methods in prevention, diagnosis, and management.

Topics to be discussed include: prenatal detection of genetic abnormalities (Dr. Ray Antley), diagnosis and management of inborn errors of metabolism (Dr. Ira Brandt), clinical implications of current knowledge regarding infant development (Drs. Gail Landy and Morris Green), management of patients with gastrointestinal symptoms (Dr. Joseph Fitzgerald), advances in pediatric hematology and oncology (Dr. JoAnn Cornet and associates), advances in pediatric cardiology (Drs. Donald Girod and Roger Hurwitz), current trends in pediatric nephrology (Dr. Carl Trygstad), pediatric endocrinology (Dr. James Wright), infectious disease (Dr. Jack Lukemeyer) and pediatric neurology (Dr. A. L. Drew).

Psychiatric Problems in General Practice

January 13, 1971 — Muncie

This six-hour course is designed to help the family physician recognize and treat emotionally disturbed patients encountered in daily practice. Participants will discuss techniques of eliciting emotional factors operative in the life of the patient, as well as ways in which such information can be used therapeutically.

Current Management of Valvular and Congenital Heart Disease

January 20, 1971 — Indianapolis

Continuing advances in diagnostic techniques and surgical therapy for valvular and congenital heart disease demand ongoing education in the management of these diseases. This course presents the latest methods for detecting potentially correctable valvular and congenital heart problems, reviews the natural history of these diseases, outlines the current criteria used for recommending surgery and discusses the current surgical management of these conditions.

INDIANA

February

Indianapolis

Urology for the Family Practitioner
2/17/71

March

Indianapolis

Electrocardiography for Physicians — 22nd Annual Course
3/3-5/71

Common Endocrine and Metabolic Problems
3/17/71

Anatomical and Clinical Otolaryngology — 56th Annual Course
3/28/71 to 4/9/71

April

Plymouth

Psychiatric Problems in General Practice
4/7/71

Indianapolis

Contemporary Clinical Pathology and the Referral Facility
4/21/71

Lafayette

A Symoposium on Trauma Emergency Care
4/22/71

May

Indianapolis

Sixth Annual Indiana Multidisciplinary Child Care Conference
5/5-6/71

June

Indianapolis

Emergency Medical Care
6/2/71

Membrane-Bound Enzymes
6/9, 10, 11/71

December

ILLINOIS

Chicago

Special Review Course in Orthopedics
12/7/70 to 12/12/70

Bronchoscopy
12/14/70 to 12/18/70

Angiography
12/15/70 to 12/18/70

Cutaneous Surgery
12/5/70 to 12/6/70

Symposium on Shock
12/18/70 to 12/19/70

Clinical Cytology
12/7/70 to 12/11/70

Gynecologic Peritoneoscopy
12/14/70 to 12/18/70

Radiation Physics and Therapy
12/5/70 to 12/6/70

Cutaneous Virology
12/5/70 to 12/6/70

Photobiology
12/5/70 to 12/6/70

Photosensitivity
12/7/70

Small Community Dermatology
12/7/70

Office Dermatology
12/8/70

Pathophysiology of Acne
12/8/70

Problems of Negro Skin
12/8/70

Pathophysiology of Acne
12/9/70

Photosensitivity
12/9/70

Lupus Erythematosus
12/9/70

Clinical Neurology
12/7/70 to 12/11/70

Office Management
12/8/70

Teaching of Dermatology
12/8/70

Rehabilitation in Chronic Skin Diseases
12/7/70

IOWA

Iowa City

Cardiac and Respiratory Disease Conf.
12/4/70

Postgraduate Conference on Obstetrics & Gynecology
12/9/70 to 12/10/70

MICHIGAN

Ann Arbor

PAS and MAP Institute
12/3/70

Otorhinolaryngology for Generalists
12/9/70

MINNESOTA

Minneapolis

Clinic Management for Doctors
12/3/70 to 12/5/70

OHIO

Akron

Visiting Professor Program
12/10/70 to 12/11/70

Cincinnati

Training Course for Audiometric Technicians in Industry

12/10/70 to 12/11/70

Cleveland

Introductory Course in Nuclear Medicine for Physicians
12/7/70 to 12/12/70

Ocular Surgery, Glaucoma & External Disease
12/9/70 to 12/10/70

Columbus

Spinal Cord Injuries Conference
12/10/70

WISCONSIN

Milwaukee

Tissue Typing
12/7/70 to 12/10/70 ◄

FUTURE MEETINGS, SEMINARS, COURSES

Colorado Offers Postgraduate Course on Surgery of Hand

Surgery of the Hand will be covered in a postgraduate course at the University of Colorado School of Medicine from February 16 to 19. Tuition for the four days is $90.00. Write the Office of Postgraduate Medical Education, 4200 E. Ninth Ave., Denver, 80220.

Contemporary Ophthalmologists To Meet in Florida March 4, 5, 6

The Society for Contemporary Ophthalmology will hold its first annual meeting March 4, 5, 6, 1971, at the Diplomat Hotel and Country Club in Hollywood, Florida. The theme of the meeting is continuing education for excellence in ophthalmology with special emphasis on modern trends in the management of ocular diseases. Individual conferences with the speakers will highlight each session.

(Registrants are invited to attend the Society for Cryosurgery meeting at the same hotel on March 1, 2, 3).

For further information: Society for Contemporary Ophthalmology, 30 North Michigan Ave., Room 1629, Chicago, Illinois 60602.

AMA Sets 12th National Conference on Sports Medicine at Boston

The AMA 12th National Conference on the Medical Aspects of Sports will be held in Boston, at the Sheraton-Boston Hotel on November 29, the first day of the AMA Clinical Convention. Non-medical athletic personnel as well as interested physicians will attend.

Two-Day Course in Ophthalmology Scheduled at U. of Kentucky

On December 18 and 19, 1970, "Practical Ophthalmology for the Primary Physician" will be given at the University of Kentucky Medical Center. This two-day course for generalists in medicine, pediatrics and family medicine will review common problems in ophthalmologic diagnosis and management. Practical methods will be stressed. Criteria will be given for identifying patients requiring specialized care. For further information regarding this program, contact Frank R. Lemon, M.D., Associate Dean, Continuing Education, College of Medicine, University of Kentucky, Lexington, Kentucky 40506.

"Fifty Years of Surgery" Course Scheduled by Cleveland Clinic

The Cleveland Clinic postgraduate course January 13 and 14 will be titled "Fifty Years of Surgical Progress." Authorities will discuss many aspects of general surgery involving the thyroid, the parathyroids, the breast, stomach and colon. The fee is $60. Address the Education Secretary, 2020 E. 93rd St., Cleveland 44106.

Monthly Series Scheduled On "Frontiers of Medicine"

The sixth series of "Frontiers of Medicine," a continuing medical education program on recent advances in medicine, conducted by the University of Chicago for physicians in practice, began this fall at the Billings Hospital, 950 E. 59th St., Chicago. The all-afternoon programs are presented monthly as follows:

November 11, 1970
Important Advances in Diagnostic Medicine

December 9, 1970
Recent Concepts in the Management of Burns

January 13, 1971
New Developments in the Treatment of Infectious Diseases

February 10, 1971
Getting to the Point with the Nervous Patient

March 10, 1971
Control of Conception

March 24, 1971
Surgical Therapy for Cardiac Disease

April 14, 1971
The Management of Renal Failure

May 12, 1971
Vascular Occlusive Disease

The program is acceptable for 29¼ elective hours by the American Academy of General Practice. A fee of $100 covers the entire series; single sessions are $15. Register by writing Frontiers of Medicine, 950 E. 59th St., Chicago 60637.

Battered Child Symposium Scheduled for Denver

The Battered Child Symposium will be conducted by the University of Colorado School of Medicine at the Denison Auditorium in Denver on November 19 to 21. Registration fee is $60. To register write The Office of Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

Chicago Medical Society Sets Ob-Gyn Postgraduate Course

A postgraduate course will be conducted by the Chicago Medical Society in Obstetrics and Gynecology on November 16 through the 20th. Meetings will be at the Knickerbocker Hotel, 163 E. Walton. Registration is limited. The fee is $150. A limited number of resident physicians will be accommodated at a reduced fee. To enroll, write the Chicago Medical Society at 310 S. Michigan Ave., Chicago 60604.

Iowa to Host Conference On Sports Medicine

A sports medicine conference will be held at the University of Iowa on Friday and Saturday morning, November 20 and 21. It is designed for physicians, coaches, and trainers. Write to Office of Medical Education, 245 Medical Research Center, University of Iowa, Iowa City 52240.

Seminar in Surgery To Be Held at Miami Beach

A Postgraduate Seminar in Surgery will be conducted by the University of Miami School of Medicine at the Eden Roc Hotel, Miami Beach, on January 13 to 16. The theme of the meeting will be "Art and Science in the Therapy of Difficult Problems in Surgery." The fee is $100. For program details and registering write Department of Surgery, University of Miami School of Medicine, Jackson Memorial Hospital, P.O. Box 875, Biscayne Annex, Miami, Florida 33152.

General Practice Review Course Scheduled for Colorado

Colorado School of Medicine will conduct three sessions of their GENERAL PRACTICE REVIEW in 1971. The course will be given from January 18 to 23 and from February 1 to 6 in Denver and from June 21 to 26 in Estes Park. The fee is $100 for the full course or $25 for selected days. For details write to The Office of Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

Allergy Course Scheduled

A Postgraduate Course in Allergy will be conducted by the American Academy of Allergy on February 20 and 21, 1971, at the Palmer House in Chicago. For full information write the Academy at 756 N. Milwaukee St., Milwaukee, Wisconsin 53202.

College of Legal Medicine Schedules May Meeting

The American College of Legal Medicine will hold a Clinical-Professional meeting at the Royal Orleans Hotel, in New Orleans, on May 7 to 9, 1971. All interested doctors are invited. Write the College at 1340 N. Astor St., Suite 1201, Chicago 60610.

Breast Cancer Conference Set for Los Angeles May 17-19

The Second National Conference on Breast Cancer, sponsored by the American Cancer Society, will be held at the Century Plaza Hotel in Los Angeles on May 17, 18, and 19. It is intended for physicians and allied scientists for the study of the problem of breast cancer from a multidisciplinary viewpoint. All interested physicians are invited. There is no registration fee. Preregistartion is requested. For further information write Esther Kelley, American Cancer Society, 219 E. 42nd St., New York City 10017.

Course Offered at Chicago

A postgraduate course in Laryngology and Bronchoesophagology has been announced for March 15 through 26 by the Department of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois at the Medical Center, Chicago.

From *The Journal* 50 Years Ago

The appearance of the tonsil in the throat is of minor importance except as to size in regard to obstruction. The adenoid, due largely to its location, is the chief offender during childhood, on account of obstruction to the passage of air, and even a moderate obstruction in the air passages from any cause not only produces general disturbance but always a local irritation and inflammation as well.

Any child who has frequent or persistent nasal inflammation should be examined for hypertrophied or infected adenoid. Chronic nasal and postnasal inflammations during childhood produce many of the ear troubles of later life. Accessory sinus disease is frequent among children and young adults and usually follows nasal infection. The sphenopalatine ganglion, the chief source of nerve supply to the nasal mucosa, is located on either side of the epipharynx and may manifest its injury from infection by an atrophic rhinitis.

The time at which tonsils and adenoid should be removed does not depend on whether the individual is 3 or 30 years of age, so much as whether there is sufficient trouble to produce complications.

Local manifestations of infection in the adult tonsil may be severe and easily detected but are apt to be less obvious, and many times it is extremely difficult to say there is or is not a focus of infection present. Statistics from a series of cases at the Mayo Clinic show that 60 percent of arthritis cases improving or recovering after tonsillectomy have never had an acute follicular tonsillitis . . . . John W. Carmack, M.D., Indianapolis, "Local Indications for Tonsillectomy and Adenoidectomy," *JISMA*, November, 1920.

Deaths

Carl Oscar Almquist, M.D.

Dr. Carl Oscar Almquist, a Gary surgeon for more than three decades, died September 20, in Methodist Hospital, Gary.

A graduate of Rush Medical School, Chicago, in 1925, Dr. Almquist, 75, attended the University of Nebraska and the University of Chicago. Credited with performing the first gastrectomy and other major surgery in Gary, Dr. Almquist was professor of surgery at the University of Illinois College of Medicine for 25 years. He was chairman of the department of surgery at Methodist Hospital for 15 years and was on the staff of Mercy Hospital. A fellow of the American College of Surgeons, he was a senior member of the ISMA and a member of the Lake County Medical Society and the AMA.

Gordon W. Batman, M.D.

Dr. Gordon W. Batman, Indianapolis orthopedic surgeon since 1924, died October 5 while visiting in Tryon, N.C.

Clinical professor of orthopedic surgery at the I.U. School of Medicine, Dr. Batman was a member of the surgical staffs of all Indianapolis and Marion County hospitals, and had been chief of orthopedic service, member of the Medical Council and chief of staff at Methodist Hospital. He was a charter member of the Indiana Bone and Joint Club and was also a charter member and first president of the Indiana Orthopedic Society, a member of the Clinical Orthopedic Society and the American Academy of Orthopedic Surgeons and a diplomate of the American Board of Orthopedic Surgery.

A senior member of the ISMA, Dr. Batman was also a member of the Marion County Medical Scoiety and the AMA. He received his M.D. degree from the I.U. School of Medicine in 1923 and was the first orthopedic resident in the James Whitcomb Riley Hospital for Children when it opened in 1924. He was a past president of the Marion County Tuberculosis Association.

Donald W. Brodie, M.D.

Dr. Donald W. Brodie, 60, Indianapolis, died in Hancock County Memorial Hospital, Greenfield, August 26.

A 1934 graduate of the Indiana University School of Medicine, Dr. Brodie served his internship at the Marion County Tuberculosis Hospital and specialized in chest diseases.

He was a member of the Marion County Medical Society and of the ISMA.

William D. Hart, M.D.

Dr. William Dawson Hart, 61-year old Anderson general practitioner for a number of years, died August 11 at his home after a long illness.

A native of Henry County, he received his medical education at Indiana University Medical School and interned at the Indianapolis City Hospital. Prior to moving to Anderson in 1944, he practiced in Pendleton and had served for two years in the U.S. Army Medical Corps. He was a member of the Madison County Medical Society and the ISMA.

Jane M. Ketcham, M.D.

Dr. Jane M. Ketcham, 90, who had practiced medicine in Indianapolis for 54 years, died September 23 at her home.

She was professor emeritus at the I.U. School of Medicine, where she had been professor of clinical medicine for many years. A charter member of the GYN Society, she served for a number of years as house doctor at a home for unwed mothers. She went into semi-retirement in 1960 after having practiced medicine since 1906, when she received her medical degree from the Purdue School of Medicine. She was a member of the Marion County Medical Society and the AMA and was a senior member of ISMA.

Elmer G. Koehler, M.D.

Dr. Elmer G. Koehler, a general practitioner at Elkhart for nearly 40 years, died August 26 at General Hospital, Elkhart.

A graduate of the University of Illinois, he interned at Grant Hospital, Chicago, and was admitted to practice in Indiana in 1929. He practiced at Columbia City for about three years before moving to Elkhart. He served in the U.S. Army in World War II.

Illuminada S. Lee, M.D.

Dr. Illuminada Santiago Lee, 52, who had offices in Hammond, East Chicago and Highland, died August 3 in St. Ann Hospital, Manila, Philippines.

On the staffs of St. Margaret, St. Catherine and Our Lady of Mercy hospitals, Dr. Lee had practiced medicine in the Calumet Region since 1958. She was a member of the AMA, the American Women's Medical Association, the American Philippine Medical Association and the Lake County Medical Society. She was a graduate of the University of the Philippines.

Florence Lyon, M.D.

Dr. Florence M. Lyon, Portland physician since 1931, died August 8 at her home following an extended illness.

She was a graduate of Philadelphia Medical College and a member of the Jay County Medical Society and the ISMA.

Robert H. Pierson, M.D.

Dr. Robert H. Pierson, 68, of Crawfordsville, died at Fort Collins, Colorado, September 21.

A native of Spencer, Dr. Pierson was a graduate of the I.U. School of Medicine. He served as a medical officer in the 348th Engineers in World War II, and had practiced medicine in Crawfordsville since 1946. He was a member of the Montgomery County Medical Society and the ISMA. The medical staff of Culver Hospital passed a resolution memorializing his passing at a meeting on October 15.

County, District News

Eleventh District

Dr. Lloyd Hill of Peru was elected president and Dr. Fred Poehler was re-elected secretary-treasurer and necrologist when the Eleventh District met at Wabash on September 23. The 1971 annual meeting will be held in Peru. The death of Dr. Charles Viney of Logansport was noted.

Cass

Dr. Eugene VanHove, radiologist at Indianapolis Methodist Hospital, discussed nuclear medicine for the October meeting of the Cass County Medical Society.

Dearborn-Ohio

"Games of Communication" was the topic of the paper presented by Dr. Bieliauskas, head of the psychology department of Xavier University, when the Dearborn-Ohio group met at Aurora on October 1.

Fayette-Franklin

Dr. Raymond Murray of Indianapolis spoke to the Fayette-Franklin County Medical Society when it met on October 13 at the Connersville Country Club. His topic was "Medical Care in the 1970s."

Grant

The Grant County Medical Society heard a panel discussion on drug abuse among young people at its October meeting. Participating were a police captain, the president of the Grant County Drug Council, a junior high school dean of girls and three local young people who had been on drugs.

Hancock

Dr. Edward Gabovitch of Indianapolis spoke on rheumatoid arthritis when the Hancock County Medical Society met on October 26 at the Hancock County Memorial Hospital.

Howard

At its October meeting the Howard County Medical Society heard Dr. Ivan Bennett of Indianapolis discuss drug abuse and drug addiction.

Parke-Vermillion

Six members were present for the October meeting of the Parke-Vermillion Medical Society meeting at Gosnell's Springbrook Club.

Wayne-Union

"Safeguarding the Health of the Athlete" was the topic of the talk given by Dr. Thomas E. Schaffer of Columbus, Ohio, to the October 6 meeting of the Wayne-Union society. Forty members and 15 guests were present. Coaches and athletic directors of schools in Wayne and Union Counties were guests.

Wells

Medical education was the purpose of the Wells County group's September meeting. A clinical conference lecture was given by Dr. Walter Daly, chairman of the department of medicine, Indiana University Medical School. His topic was "Adult Respiratory Distress." Fifty physicians from Wells County and the surrounding area attended the dinner and program.

White

Plans for the arthritis seminar to be held at Monticello on October 9 were completed when the White County group met at the White County Memorial Hospital on September 23. ◄

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Association News

BOARD OF TRUSTEES

September 12, 1970

The Board of Trustees of the Indiana State Medical Association convened at 6:00 p.m. in the Illiana Club, Terre Haute, with Dr. P. R. Petrich presiding. Roll call showed the following:

District	Trustee	
1.	Gilbert M. Wilhelmus	Present
2.	Joe Dukes	Present
3.	Donald M. Kerr	Present
3.	Eli Goodman (Elect)	Present
4.	Robert Reid	Present
5.	Wilbert McIntosh	Present
6.	Stephen Smith	Present
7.	James H. Gosman	Present
7.	Dwight Schuster	Present
8.	Richard Ingram	Present
9.	Peter R. Petrich	Present
9.	William Sholty (Elect)	Present
10.	Vincent J. Santare	Present
11.	Lowell J. Hillis	Present
12.	William R. Clark	Present
13.	Otis R. Bowen	Absent

Alternate Trustee		
1.	Eugene W. Austin	Absent
1.	Raymond L. Newnum (Elect)	Absent
2.	Betty Dukes	Present
3.	Elmer L. Wallace	Absent
4.	Jack Shields	Absent
5.	Cleon Schauwecker	Present
6.	Paul M. Inlow	Absent
7.	John O. Butler	Present
7.	Joseph Kerlin	Absent
8.	Paul Sparks	Present
8.	Robert D. Williams (Elect)	Absent
9.	Lindley Wagner	Absent
10.	Thomas C. Tyrrell	Present
11.	James A. Harshman	Present
12.	Frederic Schoen	Absent
13.	G. Beach Gattman	Present

Officers

Lowell H. Steen, Hammond, President — Present
Malcolm O. Scamahorn, Pittsboro, President-elect — Present
Lester H. Hoyt, Indianapolis, Treasurer — Present
Hugh K. Thatcher, Indianapolis, Assistant Treasurer — Present

Journal

Frank B. Ramsey, Indianapolis, Editor — Absent

Executive Committee

Donald M. Kerr, Bedford, Chairman — Present
Burton E. Kintner, Elkhart, Member — Present

Guest

James M. Kirtley, Crawfordsville — Present

Staff

Robert J. Amick, field secretary
Howard Grindstaff, field secretary
John L. Walters, field secretary
Kenneth W. Bush, administrative assistant
James A. Waggener, executive secretary

The chairman announced the Sunday meeting would begin at 9:00 a.m. at the Imperial House Motel.

Reports of Officers

PRESIDENT STEEN: I want to call one thing to your attention relating to the reference committees. In the past, Reference Committee #1 has been a committee on credentials, section work and section business and they have basically certified the delegates to the Convention. This year, I elected to assign to them not only this task of certifying the delegates, but I have assigned all the commission reports to Reference Committee #1 in the hope that this committee will read these reports. In the past the reports have basically been filed and virtually nothing has happened to them. Oftentimes they are approved by the House on a matter of faith with nobody really looking at them. This is how we got into this hassle a few years ago of approving a $500 or $1000 donation to Health Careers.

I would like to call to your attention, growing out of a meeting that occurred in Chicago yesterday of the Committee on Community Health Care of the AMA, of which I am a member, the fact that in November of 1971 there will be a White House Conference on Aging. The AMA has postured itself so as not to make any political alignment with regard to this meeting on aging, but is postured in such a way that they plan to make commitments only to the things that are medically sound and that have pertinence to the medical profession. Now the significance of this to us is that we will be ultimately asked to send a representative. I think it is very important that the Commission on Aging gear up for this and be ready for some valid input to the White House Conference. As you all know, many government conferences are sponsored with a canned party line sent out to those who attend. People break up into small groups and come back. The conclusions are written before the conference. We are assured that this is not going to be the way it is done this time. I won't believe that totally, but at least I think we ought to be ready to put in some valid suggestions to this White House Conference. I think this is a very important area in which we, as a state medical association, ought to be involved.

There has been a great increase in the activity relating to foundations in a number of the counties in Indiana. The AMA has moved off dead center and has appointed an ad hoc committee on foundations and is in the process of gathering data at this time.

Allen County is moving rather rapidly in conjunction with State Medical as an observer — we are not directly involved on the firing line at this time. Lake County has demonstrated a significant level of interest in the foundation insofar as the potential that exists in solving the Medicaid problem, and this is the area in which Allen County is operating at this time. I call this to your attention and respectfully request that this Board keep tight reign and close watch on the development in these areas and in other counties where developments occur. It is entirely possible that this may move very rapidly and I do not believe State Medical should be left out of this planning. So far we have kept our finger in, so we know what is going on. I think it is very important that the trustees continue to watch this operation closely and be abreast of the developments and be ready to move if we need to move on a state level. I think there will be some demonstration studies in some of the larger counties. I am absolutely certain something will happen in Allen County. I feel sure that in less than a year something will happen in Lake County. Let us sustain a strong and continuing interest in the foundation concept.

CHAIRMAN: We will now hear from Doctor Scamahorn, President-elect.

DR. SCAMAHORN: Foremost right now is the Retreat. Pat Corcoran, Betty Dukes, Frank Bryan and myself were charged with this responsibility. We are running into trouble the week-end of September 19-20 as both Indiana and Purdue have home football games. We are having some trouble getting the full attendance and if any of you have any ideas we would like to have at least four or five more physicians to attend this meeting. If any of you here did not get an invitation but would like to go, please see me. In case you are not aware of it, Dr. Ed Tyler, who is active in the association, has been appointed Assistant Dean of Student Affairs at the Medical School. He had a very ex-

cellent program the other afternoon, in which I represented the association for Dr. Steen. They also had Dr. Freeman Martin from Indianapolis; a recent graduate, a Dr. Arnoff of the Student Health Center in Bloomington; and Dr. George Haley. We had four discussion subjects: (1) Is there a need for organized medicine today? (2) What is wrong with the health care in America? (3) What is your pet peeve about the practice of medicine? (4) What is your pet peeve about the young physician?

It seems as though I got the majority of questions — all the bearded ones and long haired ones and the ones in the bleached-out blue jeans really gave me a rake over the coals. I thought in general I came out unscathed. I had one ask me what the AMA stand on marijuana was and if I had seen the TV release on marijuana and what I thought about it. I said, "No, truthfully I had not seen it as of then." Secondly, I do know they did ask, among other things, for more scientific research and if he was sincerely interested, and I put it that way, about the AMA stand, he could see me after the meeting and I assured him I would get the official stand of the AMA. Needless to say, the young man did not show up. I am very happy to read a letter to you which says, "Thank you very much for participating in the freshman orientation."

Later in the day several of the students came to me and told me "your part on behalf of organized medicine was the most interesting and/or I should say the most important part of their orientation. Both they and I feel you did a magnificent job and I hope that we can call on you again." The attitude, Dr. Tyler said, of many of the students was that we are a bunch of old fogies and no good, etc. This is why he asked me to "come into the Lions Den" and be bearded. I really think that he made a point because I would say roughly 80% of the questions were directed at me concerning the AMA and ISMA. These boys are not aware that organized medicine is concerned with health care delivery, that we are considering peer review, etc. These are largely students who are not exposed to the profession and I think we have a real important job to do to educate these students concerning organized medicine.

I have attended several meetings on behalf of the association. My commissions are are pretty well formed up. I am taking the privilege of naming my chairmen and I particularly want to thank Jim Kirtley, who is with us tonight, who has agreed to take the chairmanship of the very important Commission on Legislation for the coming year. Jim is knowledgeable in the mechanics of our state legislature, which is important. Secondly, I, living close to Indianapolis, have told Jim that I would take the responsibility of testifying any time it is necessary. I think we will be much more effective for the president of the Association appearing on behalf of the Association than for a member of the Commission or one of our staff men to appear. I think that a physician who takes his time to come down to the state legislature and represent the Association is going to be more meaningful and I will take that responsibility. I will represent the Association at the annual meeting of the Michigan State Medical Association and also attend the 11th District Meeting.

I have had a very interesting meeting with Mr. Robert Bales, head of the Health Committee of the State Legislature. Basically the State Legislature is unhappy and State Welfare is unhappy with the Medicaid requirements and Blue Shield's performance of them. We had a most interesting man, a Mr. Abrams, come from a computer service called "Paid Prescriptions." Paid Prescriptions started out as a computerized oriented workable service for prescriptions but is now involved in computerized total health programs under Medicaid and Medicare. They are very much interested in bidding for the work of the Indiana State Department of Public Welfare. Mr. Bales and others were very interested in having him do so. I might say I was greatly impressed with what this company can provide to us, the doctors, with their computer service, as well as a savings, which he stated he could pass on to the taxpayers of the State of Indiana.

I would like to move along to the foundation program cautiously. I would only reiterate that the State Association, Dr. Steen and I have made no commitments on the part of the State Association and we have merely been observers of what has been said. I think it is a concept which is being given great consideration and you have possibly noted that Iowa has just voted to establish a foundation. In Wyoming, rather than forming a foundation, they have formed a non-profit corporation to render Medicaid service. I might also tell you that a former classmate of mine, Dr. Fisher, who has been a medical missionary, has returned to this country unexpectedly on account of the bad health of his wife. Dr. Fisher has joined me in an associate arrangement until June 1st so now until next year I have a partner with the agreement that I can be gone any time I want to be and he will cover my practice. I will be able to spend a little more time unselfishly with the State Association.

CHAIRMAN: Dr. Jim Kirtley, will you please stand up and let the rest of the members of the Board see who you are? Jim has access to the floor of the House and the Senate and I feel that he is going to be a tremendous asset to our legislative program in the coming session.

We will now hear the Treasurer's report.

DR. HOYT: The July 31st report is in your agenda book and just this evening you were handed the copy of the August 31st report. In view of the fact that we have them both I believe we might spend the major part of our time looking at the August report. On the first page you will note we have in the checking account the amount of $119,000. This is temporary and will be reinvested so as to earn more interest. The net cash and general fund is $112,000. I think the only other item is the Medical Defense Fund of $30,000 which is a great deal better off than it was at this time a year ago. I might point out on the blue page, the investment in the Johnson Fund currently has a market value of $22,465 as of August 31 as compared to May 31, it was $21,040, so it has gained $1,400 since May. The next page is the long-term investment report. We look down at the lower right hand corner and the market value of our fund is now $57,800, which is $1,500 more than it was on May 31st, so things are looking up in some respects. The next page is the general fund income and expenses for the month. The income was $22,910 and the expenses $16,980 leaving us in the black by over $6,000. I thought you might be interested in seeing what our status has been over the past four months. As of May 31st we were in the red by $41,460; as of June 30 $30,078; July 31st $29,151; and August 31, $23,122. The JOURNAL was in the red by $662 for the month, leaving the accumulated deficit of $4,211. **This concludes my report and I move its acceptance. The motion was seconded, put to vote and carried.**

CHAIRMAN: We will next take item #5 in the agenda, Report of Board Committees. I will read only the section of Report B dealing with a change that has to do with your activity relative to this report.

"The Board of Trustees urges that all members of the House of Delegates, as well as members of this Association, continue to support the Indiana Plan for Medical Education and work toward its further implementation." This was an addendum to the motion that was made in the report that was presented to you in the July meeting. **I would entertain a**

notion to adopt the addendum to Report B. The motion was duly made and seconded, put to vote and carried.

CHAIRMAN: We will now take the last item on page 3, Report C, the addendum: "We recommend that the Commission on Medical Education and Licensure vigorously work with interested state universities to implement the program and to support legislation to accomplish these goals." At the last meeting we discussed the program of physician's assistants and/or any allied help that might be proposed in the state of Indiana. We supported the programs that were not in effect, supplementing the program for physician's assistants in line with what we discussed in Report B in regard to licensure and/or certification. We agreed that they should not be licensed, that they should be under the supervision of a physician and the Commission on Medical Education and Licensure should spell out the various training programs. **I will accept a motion to adopt the addendum to Report C. The motion was duly made, seconded, put to vote and carried.**

CHAIRMAN: We will now proceed to item 2, Report A of the Board of Trustees dealing with Insured Ambulatory Diagnostic Benefits. The last item is the only item questionable and it reads: "Therefore, The Board of Trustees of the ISMA strongly recommends that hospital staffs and Blue Shield and Blue Cross be urged to recognize testing done outside of outpatient hospital facilities for pre-admission and that the Board of Trustees is hereby requested to work toward accomplishing that goal."

The motion was discussed by Drs. Hillis, Santare, and Harshman.

CHAIRMAN: Dr. Harshman states that the staff of the Blues is supposed to have a rough outline prepared by October 1. I would hope that by the meeting on October 12th the Board might have a full, complete, comprehensive report from the committee of Dr. Santare and Dr. Harshman.

The motion was duly made and seconded that the addendum to Report A be adopted. The motion was put to vote and carried.

CHAIRMAN: We will delay the Board Liaison Committee with Blue Shield report until tomorrow as well as the Board Committee for Business Consultants for the JOURNAL. Is there any report from the Joint Board Committee on Governmental Medical Services?

CHAIRMAN: We will now take item 5 (6) Board Committee on Economic and Fiscal Matters.

DR. McINTOSH: We have nothing to report.

DR. WILHELMUS: If I may, I would like to go to item B concerning the Report J, conforming to Resolution 69-24, which has been sent out by Mr. Waggener. You are now receiving a copy of this Report J. I would like every one to look at it to see if it is a satisfactory report to the House of Delegates because you will note we are asking for a $10.00 dues increase and face a deficit of $9.88 per member for the coming year. I am hoping that everyone agrees this is sufficient for the House of Delegates. **I would so move the acceptance of this report.**

CHAIRMAN: **It has been moved and seconded that this report be approved for presentation to the House of Delegates.**

DR. SCHUSTER: I am in favor of this but I would like to know if the loss on the convention is on the past or coming convention.

CHAIRMAN: This is on the coming convention. We are planning on losing quite a lot of money, even in excess of $10,000. **If there is no other discussion — all those in favor of the motion say "aye"; opposed — the motion is carried.** Now Item C—Employees Retirement Plan.

DR. WILHELMUS: My interpretation is that this was an agreement to be worked out by the Board of Trustees with the employees in order to make their current retirement plan concur in the recent Federal regulation. The Board felt that Mr. Waggener and his employees should discuss this and help decide on what type of plan we should accept. There has been no definitive action taken at this point; therefore, I have no further report.

CHAIRMAN: **We will accept this as your report. All those in favor of accepting the report of Dr. Wilhelmus say "aye" and opposed same; the report is accepted.**

CHAIRMAN: We will now go to the Joint Board Committee on Medical Services.

DR. INGRAM: I have no report at this time.

CHAIRMAN: We will now move to the Board Committee report on the Orientation of New Members.

DR. CLARK: We plan to bring the Board resolution before the House of Delegates in which we ask them to change the Constitution and Bylaws to delete the mandatory orientation program. I will take the responsiblity of following this through with the Reference Committee.

CHAIRMAN: Thank you, Dr. Clark, for a job very well done. **On motion of Drs. Kerr and Schuster, the report of Dr. Clark was approved.**

CHAIRMAN: We will now proceed to item 9, Ad Hoc Committee on Medical Use of Computers.

DR. REID: I have with me the basic format of the history program which I would be glad to discuss with anyone who is interested. We are at the present time beginning discussions with physicians in communities over the state hoping to establish local communities to work with us in finalizing our program. We have a communication problem in getting people to understand what we are attempting to do and why. One important facet we should begin thinking about is what we are going to do with the accumulated data which we will be compiling. I would suggest that the Board begin to think about an appropriate structure to have some supervisory role over such data. The report was discussed by Drs. Kerr, Harshman, Hoyt, Petrich and Ingram.

CHAIRMAN: **It has been moved by Dr. Kerr and Dr. Gosman that the report of the Ad Hoc Commitee on Computers be accepted. The motion was put to vote and carried.**

DR. GOSMAN: If it is appropriate, this Board might take action on Dr. Reid's suggestion to form such a committee.

CHAIRMAN: We have a committee which is chaired by a man who has a very personal interest in the computer organization.

DR. HARSHMAN: **I would move on the suggestion of Dr. Reid that this committee be enlarged and changed to a standing committee. The motion was seconded by Dr. Kerr.**

DR. STEEN: Instead of this being a standing committee, until you get your

feet on the ground and determine direction, **I move to amend the motion to make this an Ad Hoc Committee of the Association.**

CHAIRMAN: **The motion to amend has been seconded by many.** Any discussion? **The motion was put to vote and was carried.**

DR. REID: I hope I was clear that this committee is to concern itself with accumulated data primarily so that it does have some strength.

CHAIRMAN: We will now move to the Ad Hoc Committee on Education.

DR. GOSMAN: Report E of the Board pretty well covers our previous actions and the action on Resolution 69-13 and 69-15. Basically we feel that a statewide education program will considerably increase our medical student enrollment. We felt, on the basis of our study, there were evidences of additional men entering in general practice. We concurred with the development of the Chair of Family Practice at the Indiana University School of Medicine. We felt that the nursing profession should take greater steps in becoming the allied medical personnel which we hear so much about. Perhaps technicians and clerks coming out of the service might be considered appropriate for some of the additional help in our field, particularly in our computerized phases. Group practice by physicians using the Tell City Clinic Plan was specifically pinpointed as an example of what could be done in small communities. Resolution 69-18 deals primarily with scholarship and residency programs in our hospitals. We should make every effort to develop a program where many practicing physicians could go back to school for a month or two months in some subject for which he would be credited. At Methodist just last week we had a man who was a resident and he was asked to come back for a month in a particular field and then go out in general practice. This is an agreement with his associates and I think this is a wonderful idea. **I move the adoption of these two portions of my report.**

CHAIRMAN: **Dr. Gosman moves the adoption of his report. Seconded by many — any further discussion? The motion was put to vote and carried.**

DR. GOSMAN: I will have Report G in final form for discussion at our session tomorrow.

CHAIRMAN: We will now move to item 13, Ad Hoc Committee to Study Parliamentary Procedure.

DR. HOYT: I have not as yet completed my study and I am comparing five different parliamentary procedures plus the AFL-CIO booklet on How to Run a Union Meeting. Therefore, I am not ready to make a recommendation at this time.

CHAIRMAN: We will move to Report I, Convention Sites and Facility Requirements.

DR. STEEN: **Since we have discussed this before and have all studied it in great depth, I move that we accept it by consent.**

CHAIRMAN: **Dr. Steen has moved acceptance, seconded by Dr. Kerr and Dr. Ingram. Any further discussion? If not, I will call the question. The motion was put to vote and carried.**

CHAIRMAN: We will move now to Item 15, Matters Referred by the Executive Committee.

DR. WILHELMUS: **I move this report be deferred until 9:00 a.m., Sunday morning. Seconded by Dr. Steen, put to vote and carried.**

CHAIRMAN: Dr. Jim Kirtley has requested that he be permitted to make a report as Chairman of the Governor's Commission on the Handicapped.

DR. KIRTLEY: I appreciated the opportunity of appearing before the Board to report to you that during the past three years we have made some definite progress in getting things done for the handicapped. I want to thank the members of the medical profession for assisting us in getting some laws passed during the last legislature. The result of one of these laws is the sheet which I am passing around to you at this time which is the reporting form which I know the medical profession is going to be a little unhappy about, if and when they are asked to fill in this information. This form is prescribed by the Indiana State Board of Health according to Chapter 404 of the Indiana Acts of 1969. This is a report form on case reports for individual handicaps or handicapping conditions. You will note on the reverse side all the things we consider to be handicapping. It would seem this is going to be a tremendous job so I would like to explain what we are trying to do with this information. This will all be computerized and kept confidential. Hopefully the information given is gleaned from these reports and that physicians, in turn, will have information fed back to them in many ways. We are sure we will find many handicapped in every community and in some cases we do not know what to do with them. After we get the initial reports, it would be an on-going job, just as we fill out our birth defects. For example, if you have a paraplegic you will be asked to fill out this form so that patient can be given guidance as to where he can be given help or referral to private or state supported agencies to assist him in making a living and getting back on his feet. I hope the Board of Trustees will support this action. We hope that all physicians will cooperate. You will not be the only people who will be required to turn these in. There will be overlapping. However, these will be cleared out through computerization. In addition to physicians, hospitals, school corporations will also be required to file these forms.

DR. STEEN: Under Part IV where it says Medical Data "NOTE: Only physicians are required to complete this part of the report." Is that what it really means?

DR. KIRTLEY: That means a school teacher or technician does not make a diagnosis.

CHAIRMAN: **Dr. Steen has moved we accept the report of Dr. Kirtley and commend this to the membership as a laudable cause. The motion was seconded by many. Dr. Ingram makes a motion to table this which dies for a lack of a second. Is there further discussion on the motion to accept the report?**

DR. INGRAM: We have not had time to study this. This makes reportable virtually 90% of the cases I see in my office that qualify as a handicap. Besides that, just as general philosophy, I am opposed to granting any additional information on patients of mine or myself to any governmental or quasi-governmental organization.

The matter was further discussed by Dr. Kerr and others.

CHAIRMAN: We have before us a motion to accept a report and to commend it to our membership as proposed by Dr. Kirtley and it was duly seconded. Any additional discussion?

DR. INGRAM: **I would like to amend the motion to strike the word "commend" and use the word "advise" our membership.**

CHAIRMAN: **The motion has been made to substitute the word "advise" for "commend." The motion has been seconded by Dr. Steen. Any discussion on the amendment? There being none, we will call for the question. The motion was put to vote and carried.**

Ve will now vote on the main motion s amended. The motion, as amended, as put to vote and was carried.

OARD OF TRUSTEES

September 13, 1970

The Board of Trustees reconvened at :00 a.m. at the Imperial House Motel, erre Haute, Indiana, Sunday, September 3, 1970.

Roll call showed the following:

District	Trustee	
1	G. M. Wilhelmus	Present
2	Joe Dukes	Present
3	Donald M. Kerr	Present
3	Eli Goodman (Elect)	Present
4	Robert Reid	Absent
5	Wilbert McIntosh	Present
6	Stephen Smith	Present
7	James H. Gosman	Present
7	Dwight Schuster	Present
8	Richard Ingram	Present
9	Peter R. Petrich	Present
9	William Sholty (Elect)	Present
0	Vincent Santare	Present
1	Lowell Hillis	Present
2	William Clark	Present
3	Otis R. Bowen	Absent

	Alternate Trustee	
1	Eugene W. Austin	Absent
1	Raymond L. Newnum (Elect)	Absent
2	Betty Dukes	Present
3	Elmer L. Wallace	Absent
4	Jack Shields	Absent
5	Cleon Schauwecker	Present
6	Paul M. Inlow	Absent
7	John O. Butler	Present
7	James Kerlin	Absent
8	Paul Sparks	Absent
8	Robert D. Williams	Absent
9	Lindley Wagner	Absent
0	Thomas C. Tyrrell	Present
1	James A. Harshman	Present
2	Frederic Schoen	Absent
3	G. Beach Gattman	Present

fficers:

owell H. Steen, president	Present
Malcolm O. Scamahorn, president-elect	Present
ester H. Hoyt, treasurer	Absent
ugh K. Thatcher, assistant treasurer	Present
rank B. Ramsey, editor, *The Journal*	Absent

Executive Committee:

onald M. Kerr, chairman	Present
urton E. Kintner, member	Present

Delegates and Alternate Delegates to AMA:

Don E. Wood	Present
Eugene Senseny	Absent
Frank Green	Absent
John S. Farquhar	Absent
Jack Shields	Absent
James Harshman	Present
Eugene Rifner	Absent
Kenneth Neumann	Present
Patrick J. V. Corcoran	Absent
Thomas C. Tyrrell	Present
Lall G. Montgomery, AMA Section on Pathology	Absent
Sprague H. Gardiner, AMA Section on OBGYN	Absent
Myron H. Nourse, AMA Section on Urology	Absent

Guests:

Andrew Offutt, Secretary, Indiana State Board of Health	Absent
Joe M. Black, Chairman, Blue Shield Board	Present
Richard Kilborn, President, Mutual Medical Insurance, Inc.	Present
Glenn W. Irwin, Dean, Indiana University School of Medicine	Present
Pete Foster, President, Indiana Chapter Student AMA	Absent

William C. Shriner, M.D., Terre Haute
Burton E. Scherb, M.D., Terre Haute
Thomas J. Conway, M.D., Terre Haute
Charles E. Moon, M.D., Brazil

Staff:

Robert J. Amick, field secretary
Howard Grindstaff, field secretary
John L. Walters, field secretary
Kenneth W. Bush, administrative assistant
James A. Waggener, executive secretary

CHAIRMAN: We will hear reports from our guests at this time and will call on Dr. Irwin, Dean of the Indiana University School of Medicine.

DEAN IRWIN: We have had an interesting week in that we had on campus, beginning last Tuesday, the new freshmen medical students. There are 250 in the entering class this year. These were selected from 1266 applicants. Of the 1266, 586 were in-state students. You might be interested to know that the average academic performance of these 250 students was 3.3 on a 4.0 scale. Just five years ago, in 1965, the academic average was 3.0. Another remarkable thing is that the medical college admissions test average this year for the freshman class was 65 compared with 46 in 1965. In the class are 27 women; 8 out-of-state students and 5 black students. 200 of these students will be on the Indianapolis campus; 30 at Bloomington; 10 at Notre Dame; 6 at Purdue and 4 at Ball State. I was asked about the Admissions Committee, which was chaired this year by Dr. James O. Ritchey, and consists of 30 members, half of which are made up of practicing physicians primarily in the Indianapolis area. All of them are on the volunteer faculty. I would estimate that at least 14 to 16 full days per year are required on the part of the entire Admissions Committee to review the applications for medical school. Just a few words about the faculty—during the past twelve months we have appointed fifty full time additions to the faculty. During this same period 33 have left us for other medical schools. We have added 20 part-paid members. These are largely people who are in the Marion County General Hospital and in the VA Hospital and some of these men are from out of state. This year we have added 63 new volunteer members to the faculty. The volunteer group now numbers over 500. As to facilities, we have completed the first phase of the University Hospital, comprising 249 beds. We have closed down most of the Robert Long Hospital. The second phase of the University Hospital should have been under construction a year ago but we encountered one roadblock after another. The most recent roadblock has been over the question of the hiring of minority groups. This has been a federal government and union problem and is not completely resolved. We hope, however, that construction will get underway in 90 days. The second phase of the University Hospital includes a radioisotope center which will be underground in front of Emerson Hall. The departments of OBGYN will move into the Hospital, so that Coleman Hospital can be closed for its present function when the second phase is completed. Clinical laboratories and many other departments will move into this hospital on completion of the second phase.

Now a few words about our programs. As you know, all of us are up to our hub caps on the question of statewide medical education. With the General Assembly coming up in January and February, we have our work cut out for us. I have possibly reported to you, and you are familiar with the so-called seven-center program. I would say, in my opinion, fairly good progress has been made in extending the statewide system for medical education. At times we feel we are being pushed a little more rapidly than is wise from an academic education standpoint. Fortu-

nately, the resolution adopted by the Governor's Commission on Medical Education leaves it up to the School of Medicine to establish such important things as accreditation, which is a must, because if we did not have this kind of control we would lose our accreditation and this would mean disaster for the School of Medicine. We are in a planning year, as far as the Governor's Commission is concerned, and there have been identified, on a one-year basis, directors for these medical education centers in all areas but two, Evansville and Lake County. However, several good candidates are now being considered in both of these cities and when they are identified then each of the seven centers will have a director.

I think you would also be interested to know that the senior medical students who now have an elective year for two years, 66% of the time of all the students for this year will be spent off the Medical School campus. Only one third at any given time will be in the Medical School for this elective year. About half of the 66% are in community hospitals in the Indianapolis area and the other half are out over the state, either in community hospitals, preceptorships, group practices, etc. I am convinced when this large number of medical students see what can be offered educationally throughout our state, we are going to have a more favorable number of interns and residents and thus more practicing physicians in Indiana. The first phase of the statewide program of medical education, which this association sponsors, and which the General Assembly approved in '67, has been working real well. It has been under-funded; hospitals have not received the kind of fiscal support they perhaps should have had, but at least the program is on-going. The program was designed to prevent the Indiana brain-drain because we are graduating 200 students and maybe keeping 90 in the state. I am happy to report that this year, 1970, there are 103 additional interns and residents in Indiana hospitals. Three years ago, before the program started, we had interns in only two cities, Indianapolis and South Bend. We now have interns in Evansville, Fort Wayne, Muncie and Lake County, as well as South Bend and Indianapolis.

I am sure the question of additional medical schools will be debated again and I do not know how many, or at which time one or more of these regional centers, which are being created, will become a full-fledged medical school.

I appreciate the support of this organization. The pressures have been great on us and also on your association, but I do believe it is basically under control from the standpoint of education and from the standpoint of organized medicine. I do think Indiana will pull off a truly unique statewide program which will serve us in its interim program.

The report was discussed by Dr. Gosman concerning grading; Dr. Wilhelmus concerning the selection by students for location of training; Dr. Kintner regarding training of physicians' assistants; Dr. Hillis regarding the honor system; Dr. Schauwecker concerning the intern and residency programs; and Dr. Steen on the same subject.

CHAIRMAN: Thank you, Dean, for the excellent report and we certainly appreciate your making the journey to be with us today. Let us now return to deferred matters from yesterday. The minutes were deferred. All of you have had an opportunity to peruse the minutes of July 26th. **The motion was duly made and seconded that the minutes be approved.**

DR. HILLIS: **I call attention to a typographical error on page 30, line 13.**

The minutes were approved with the above change.

CHAIRMAN: We will now move to matters referred by the Executive Committee; Dr. Kerr.

DR. KERR: We have discussed the Blue Cross-Blue Shield relationship and its Advisory Group to the Medical Assistance Program. Also the obtaining earlier payment of physicians and their being paid their usual and customary fee, at least up to the 75th percentile of their fees. We also discussed the possibility of another group running the Medicare and Medicaid Program other than Blue Cross-Blue Shield. There was a recent meeting at the Columbia Club with a group who have been working with the San Joaquin Valley Foundation and other foundation groups and from their reports they feel they can do a more precise, economical and effective program in administering the Medical Assistance Program. I would like to have Dr. Scamahorn tell you about this meeting.

DR. SCAMAHORN: First of all, I want to say that we were asked there as observers only. We made no commitment nor have we made any commitment to this group. Mr. Robert Bales, who is Chairman of the Legislative Committee on Health, and his committee asked "Paid Prescriptions" to come and talk to this committee and a group from Fort Wayne who were interested in the foundation approach as well as representatives of Lake County. Paid Prescriptions is a computer organization which was underwritten by Eli Lilly and Smith Kline & French. When the prescription problem in California was getting out of hand, this organization devised a service which does more than just pay bills as it has built into its service a method of reporting whether the patient is receiving or using a prescription or, say, the same class of drugs. For instance, is a patient taking two antibiotics? The system also identifies the patient as to whether or not he is receiving prescriptions from different physicians. This service has many safeguards. As you know, this has been one of the big drug abuses and one of the big problems in the Medicaid program. They also then took over the responsibility of the San Joaquin Foundation in providing facts such as these plus others, such as over-utilization and peer review. The Medicaid cost in Indiana is four times that of the same group in California per recipient. The Indiana legislature is real upset. They are still upset with the Blue Shield performance. This group met with Mr. Starrett and the legislative committee the following day and they are very interested in bidding for the job of handling the Indiana administration of the Medicaid program. It was a very interesting and enlightening discussion. I was very much impressed with this organization. I think they could provide a lot of good information at a minimal cost. They pointed out some very bad faults in our present system. The representative made the statement that if they could not save the State of Indiana $10,000 the first year, they would give up their contract and were willing to put such a clause in their agreement. They felt they could save 25% of the administrative cost and 10% of the over-all cost of the program. One thing that impressed me about their system was that the physician, when he gets a printout on the 15th and 30th of the month, would also receive a complete report of the status of every claim the physician had filed for his patients. This way the physician would know exactly whether his claim was in process and would obviate the necessity of calling in to find out about claims as he does now.

DR. KERR: There was no action to be taken on this but I thought it should be presented to you briefly for your information.

The next item was that of state conventions. We are already committed to French Lick, but as you know Indianapolis will shortly have a convention center. Mr. Waggener has been in touch with the people who are managing this convention

enter and the information we have makes t, at least in the opinion of the Executive Committee, more than a little clear that ve should try to keep our annual convention in Indianapolis because of the facilities for cash income and attendance. There s an estimate that we will lose as much as 10,000 on the convention being held in outh Bend. It is also true that the House f Delegates, according to the Constitution nd Bylaws, has the prerogative of stating here we should go. It is also true that here is a resolution being presented this ear, hopefully to put the matter of a hoice of a convention site in the hands f the Board, who will certainly be more onversant with the problems. I would like Ir. Waggener to explain to us what is vailable in Indianapolis.

IR. WAGGENER: The new convention enter has offered us a contract for 41,000 quare feet of exhibit space. This would ermit us to have 10'x10' exhibit booths nd 10' aisles between the booths and also offer to our exhibitors adequate space or some of the free-standing exhibits that re now becoming so popular. In addition this, the convention center will remove nd store the crates and return them to ie exhibit hall, which would be an additional savings over other convention sites e have used. In addition, there are 28 ieeting rooms which will be available to s in the same facility. This would handle l the section meetings, reference committees, specialty groups and everything se for a flat fee of $3,000.

HAIRMAN: I would also point out to ou that we have Report I of the Board f Trustees which gives the necessary reuirements of convention sites and also me recommendations from the Commison on Constitution and Bylaws. I would ke to deal with this subject now.

The matter was discussed by many embers of the Board.

HAIRMAN: **Dr. Gosman has moved ie acceptance of Report I. Seconded y many. The motion was carried, ith Dr. Wilhelmus registering a "no" ote.**

R. KERR: The Executive Committee fers to the Board the matter of operion of a hospitality room during the MA session in Boston, as to the hours should be kept open and whether or not ere should be a continuation of the eakfast meetings of the delegation. It as the consensus of opinion of the Executive Committee that the room should be pt open from 5:00 p.m. to 7:00 p.m. on ovember 29, 30 and December 1, and that there should be breakfast meetings. The Board will have to OK the expenditure of funds for the hospitality room.

CHAIRMAN: This would be an appropriate time to hear from the floor representatives of the AMA delgeation. Dr. Harshman and Dr. Neumann are both here. Do you have anything to add?

DR. HARSHMAN: While we are talking about the organization of the delegation and hospitality room, I personally feel that we should, as a group, decline any invitations from other parties for evening engagements that take away the time from the hospitality. I think that as long as there is business at hand, we have a responsibility to stick pretty much to it. If we have time to play afterwards, that is fine. I am opposed to closing the room in order to meet a social obligation.

DR. NEUMANN: I don't think we have closed the room for other obligations. Number 1, the committee has already determined the hours will be from 5:00 p.m. to 7:00 p.m. I think in the past we have stuck to this fairly close. I would agree with Dr. Harshman that there is some problem when the I.U. Alumni group had something planned earlier in the evening than the 7:00 p.m. hour. Otherwise, beyond the hour of 7:00 p.m., about all we get in the room are drifters and freeloaders.

DR. KERR: This also extends the expense if we extend the time.

DR. GOSMAN: **I move that this Board approve the expenditure and the recommendation of the Executive Committee for operation of the hospitality room and the delegation breakfasts.**

The motion was discussed by Dr. Schuster; put to vote and carried.

CHAIRMAN: We will now go to item 10 (d), which will also encompass item 12, Report G to the House of Delegates.

DR. GOSMAN: This committee met yesterday afternoon, consisting of the Executive Committee and myself, and we have come up with the following suggestions:

Peer Review (Report G)

Medical review is an education process for the reviewers and those who are reviewed and assists medical societies through this endeavor in collecting important data useful to the profession in providing better health care to the public which they serve and to refute the false claims of our critics. Medical Review is a term describing the activities of physicians in observing, monitoring and reviewing the professional activities of physicians exclusively by their colleagues, including total patient care, fee review and identifying practice patterns.

In joint county societies it is suggested that a single medical review committee be structured. Small societies with limited membership may find it feasible to form a single medical review committee in conjunction with one or more other small societies.

The Indiana State Medical Association will also develop a Medical Review Committee to aid and assist the County Medical Review Committees and the President will be directed to appoint this Committee with the approval of the Board of Trustees.

Finally, the Medical Review Committee will be a standing committee of the ISMA.

I move the acceptance of this report.

CHAIRMAN: You have heard the report. It has been moved and seconded. Any discussion?

The motion was discussed by Dr. McIntosh, Dr. Clark, Dr. Ingram.

CHAIRMAN: **Dr. Ingram has moved that we table this until the October 12 meeting. The motion was put to vote and the motion failed.**

The motion was further discussed by Dr. Thatcher, Dr. Kerr, Dr. Ingram, Dr. Steen and Dr. Scamahorn.

CHAIRMAN: **There being no further discussion, I will now call for a vote on the motion. Dr. Ingram requests a roll call vote:**
Wilhelmus, yea; Dukes, nay; Kerr, yea; McIntosh, yea; Smith, yea; Clark, yea; Gattman, yea; Steen, yea; Scamahorn, yea; Thatcher, yea; Gosman, yea; Schuster, yea; Ingram, nay; Petrich, yea; Hillis, nay; Santare, yea. The vote is 13-3 in favor of adoption of the report and the report is adopted.

With respect to item 16, I sent a letter to Dr. Stonehill reporting the Board's action withdrawing the support of ISMA to the Regional Medical Program. I received back from him a request for reasons why the Board took such action. I merely report this as information and that will be an item for our agenda in a future meeting. Dr. Ingram, I believe this is an area in which you wanted to make a comment.

DR. INGRAM: Dr. Steen called and asked me to attend the Indiana Regional Medical Program — Long Range Goals and Objectives Committee meeting. I attended. First of all, the reason for this

committee's existence was to establish long-range goals and objectives for the RMP program in such a way that it could be presented to HEW in a format to meet the requirements of HEW to annually review all regional medical programs. The goal of this committee was to get an on-going plan over the coming years to present to this review committee so that they could get their funds. This was the first meeting of this committee, and I think I was the only one there who has not previously been involved in this program. When we got to the meeting we were handed a great sheaf of material, a part of which I have reproduced, so that everyone can see it. There is no action on it so it was not necessary to get it around ahead of time. All of the work of the committee was previously done by the staff and Dr. Stonehill. The action of this committee amounted to a discussion of about an hour long between myself and all other members, me on one side and all the others on the other side, with a blanket approval of his long range goals and objectives with one dissenting vote — mine. Those are the facts.

The commentary is that Dr. Stonehill has made this all-inclusive. His goal is to get into all areas of health care delivery at all levels. His goal also is to encompass all the comprehensive health planning councils and all Federal functions within this state so that ultimately all the control will be within this one group. I won't make any more comments except to recommend that this reprinted material, particularly the three sheets setting forth long range goals and objectives, be carefully reviewed. I cannot miss passing on to you that I made the statement that if they hoped to have any sort of support from the physicians in this state they would have to keep this operation primarily out of the delivery business and let it remain in the educational business, as it was originally supposed to be. As far as I know, there is not a future meeting of this committee, unless it is next year. I hope the president, in his wisdom, will appoint someone who does not get as upset as I do if they have to attend.

CHAIRMAN: If there is no further discussion relative to this particular subject we will now move on to the discontinuance of the mandatory Orientation Program. The resolve reads: "Resolved, that this House rescind its previous action thereby abolishing the Orientation Program but strongly urge that all county societies establish an Orientation Program suited to their individual needs." Also we have Resolution 70-2, Reduction of the Number of Residency Programs.

The motion was discussed by Dr. Neumann, Dr. Thatcher, Dr. Steen and Dr. Schuster.

DR. SCHUSTER: **I would like to move that this be amended to carry forth the ideas which we have discussed, that the AMA Council on Education review the programs and eliminate those which are marginal.**

CHAIRMAN: **It has been moved and seconded to have someone at the Reference Committee to recommend the changes as discussed. The motion was put to vote and carried.**

Next is Resolution 70-3, calling for a study of a relative value concept. Resolution 70-4, dealing with the establishment of a group to establish equitable payments; 70-5, express opposition to the Governor's Commission on Medical Education; also Resolution 70-7 through Resolution 70-28.

CHAIRMAN: We will now call on Dr. Black, Chairman of the Board of Blue Shield.

DR. BLACK: Last year Blue Shield paid 1,200,000 claims and dispensed $48,000,000, which was an increase of about $10,000,000 over the previous year. This year, at the rate we are going, we will probably process close to 5,000,000 claims, about 50% of which are government programs. There are some new programs being developed by the Blue Shield Board which we hope will help physicians. You know that you are now charged to carry out utilization review and the work you do under government programs. We are doing a form of this with the help of computers in reviewing claims of various physicians in the state of Indiana. I get an opportunity every week to look over the unusual claims that come out of this computer. You would be surprised at some of the information. Today we are paying 75% of our money to 25% of the physicians in our state. I think utilization review is going to help us and as we progress further we are going to have the field staff go out and explain to each county society what we can give them in the way of utilization review. Fifty percent of the problems of the Medicaid program right now are from wrong information coming from the doctor's office. Another 50% of the program are our problems. When your meeting comes up this next month I am most interested in one resolution which passed two years ago which limits the length of time a Board member may serve on the Blue Shield Board. I feel we are having difficulty finding men who will work at being good Blue Shield Board members. We also have difficulty in edu cating these men on Blue Shield service and policies. I feel this insurance compan is being handicapped by limiting a goo man to a six-year term. Major corporation don't do this. If they have a man who i performing well, they leave him in th job and let him do it. We are getting som men today whom I hate to see have thei terms limited to six years. We have bee reviewed by HEW, Social Security, an also a private corporation, and they say w are doing one of the better jobs in th country in the administration of the Med caid program. Mr. Kilborn is here toda and I would like for him to have th opportunity to tell you about the function of the company at this time, but I do re quest that you think a little about th question of limitation of the tenure o our Board members as this is a big busi ness — $48,000,000 last year, with re serves of over $20,000,000.

MR. KILBORN: I will be glad to dis cuss the qualifications of a Board memb ber from your districts.

CHAIRMAN: Thank you, Dr. Black. Dr Black brings up the point of the tenur of Blue Shield Board members. You wil recall on several occasions we have intro duced resolutions that we not limit th terms to two terms consecutively and second, when they failed we attempted t increase the term which would in effec limit their time on the Board. We have n such resolution right now before the Board Does the Board wish to take any action o it today?

The matter was discussed by Dr. Harsh man, Dr. Scamahorn, Dr. Steen, Dr. Blac and Dr. Kerr.

DR. KERR: **I move that the Board o Trustees Liaison Committee with Blue Shield be assigned the task of present ing a resolution or a mechanism for a solution of this problem.**

CHAIRMAN: **Dr. Kerr has moved seconded by many. Any further dis cussion? The motion was put to vote and carried.**

CHAIRMAN: Mr. Kilborn, do you have any additional comments?

Mr. Kilborn explained a little more in detail the policies of utilizaiton review being done by the Plan. A report of the Plan would show a loss of about $3,000,000 through July 31. Mr. Kilborn also elabo rated on the work load and the term o Board members.

The matter was further discussed by Dr. Harshman, Dr. Tyrrell, Dr. Wood, Dr Thatcher and Dr. Neumann.

CHAIRMAN: Much of this discussion has been dealing with Blue Cross. Let us empower Dr. Santare and the Liaison Committee with Blue Cross to investigate various items in this discussion and report back to us at the next meeting.

We will now move on to item 5, nomination of two members of the Editorial Board for a two year term ending December 31, 1973, to succeed Dr. Snively of Evansville and Dr. Bennett of South Bend.

DR. KERR: **I move that Dr. Elton Heaton be elected to replace Dr. Bennett of South Bend.**

DR. GOSMAN: **In addition, I call to our attention the fact that Dr. Jack Hickman who was currently on the Board has left Indiana, and the 7th District would like to nominate Dr. Beering to succeed Dr. Hickman.**

DR. STEEN: **I move that Dr. Snively be re-elected to succeed himself.**

CHAIRMAN: **If agreeable, we will vote on the three nominations — namely, Dr. Heaton, Dr. Beering and Dr. Snively.**

The motion was put to vote and the three men were elected.

CHAIRMAN: We have an item of business now on your agenda — a Mr. Weiss of DATAaide is here to discuss the billing of dues and other services. Mr. Weiss is president of a company which handles a similar computerization for the Illinois State Medical and who will also be handling Iowa.

Mr. Weiss explained their operation and how it tied in with the activities of the ISMA, which provided more services for the association than is now being done through its present program and also would be a slightly higher cost service than the association is now paying.

DR. STEEN: **Mr. Chairman, I move this entire matter be referred to the Board Committee on Fiscal and Economic Matters after Mr. Waggener has made an appropriate breakdown of our costs, staff time, etc., so they can adequately evaluate the pros and cons of the program with all the facts at our fingertips and report to the next Board meeting.**

The motion was seconded by many.

DR. STEEN: **The thing I was hoping to do was to expedite this so that if a change was to be made it could be made effective the next fiscal year.**

CHAIRMAN: **The motion has been editorially corrected. All those in favor say "aye", opposed? The motion was carried.**

We will now call on Dr. Dukes, Chairman of the Liaison Committee with Blue Shield to report on Resolution 69-27, which has been referred to his committee.

DR. DUKES then read the following, which was labeled Report D.

There is misunderstanding and confusion regarding the Blue Cross-Blue Shield insurance certificates. Such misunderstanding and confusion is brought about because of many different contracts which are primarily negotiated between the unions and management getting together and deciding what they want and what they will pay for. They then ask the insurance carrier how much they will charge for such contracts. Basically in the past there have been Standard, Preferred, Usual and Customary policies. (However, no more Standard Policies will be sold.)

Many of these policies are inadequate to protect Blue Shield certificate holders, even the policies which are primarily determined by what labor and management want and the amount of money available to provide such.

No physician is present or participates officially in discussion of coverage presented to major corporations for medical coverage. We believe possibly a physician present could be of aid. However, union and management usually have already made up their minds of what they want. Also many contracts are negotiated out-of-state, such as New York, Detroit; the Plan then is forced to go along or not participate at all. More than 60% of Blue Shield business is this kind.

There is marked discrimination of compensation among medical, surgical care and hospital benefits. We do not know how this is determined. To our knowledge a computer does this.

We recommend that the Board of Trustees of the Indiana State Medical Association review the certificates of Blue Cross and Blue Shield and offer recommendations to improve the coverage of Blue Cross and Blue Shield certificates. A review might be made, but consideration must be given to what the individual wants, what the physician wants and what the carrier can provide for the amount of money involved.

We further recommend that the Board of Trustees of the Indiana State Medical Association report its findings to the House of Delegates of the Indiana State Medical Association at its next annual meeting in 1971.

DR. STEEN: Mr. Chairman, I would like to comment on the resolution. If I remember correctly, the intent of this resolution was to attempt to delineate and point out the features inherent in an ideal health insurance program. It seems to me the last discussion was that we were to develop a resolution calling for minimal standards in health insurance that we as a state association believed to be the ideal elements in an ideal health insurance program. It would appear that your committee, although it worked very hard, has developed a resolution that is somewhat at variance with what I believe the Board asked for. In the resolution you ask for a review of the current policies available under Blue Shield and I believe we pointed out at the last Board meeting there are probably 80 or 90 contracts, some of which are no good, some of which were so expensive they could not be sold, and I believe that the consensus was that we should furnish some leadership as to what constitutes a good, basic, inclusive insurance coverage for the average family of two, three, four or five people. Is that not correct?

The motion was further discussed by Dr. Steen and Dr. Dukes.

CHAIRMAN: **Dr. Dukes moves acceptance of his report, seconded by several. There being no further discussion, the question is called. The motion was put to vote and carried.**

Discussion then ensued between Dr. Gosman, Dr. Kerr and others concerning the relationship between Blue Shield and ISMA and the previous action of the Board concerning presenting a resolution to the House of Delegates divorcing the association from Blue Shield.

I remind the Board that we did have a motion, duly seconded and then moved to table and the motion was passed at the previous meeting of the Board.

DR. INGRAM: **I would like to move that we bring from the table the motion of Dr. Steen that we in fact divorce ourselves from Blue Shield.**

CHAIRMAN: A two-thirds vote is needed to remove this from the table. We now have a resolution that was adopted by this body.

DR. STEEN **then read the minutes of the meeting of the Board concerning the divorcing of ISMA from Blue Shield. The motion was: "That we introduce a resolution from the Board of the House of Delegates voicing our strong rejection to the change in attitude and action of the Blue Shield Board and that we**

hereby sever all relations with them henceforth and forever more."

The motion was seconded by Dr. Ingram and discussed by many.

CHAIRMAN: **This motion has previously been tabled. Now we are going to consider the motion to remove from the table. A roll call vote has been requested. Wilhelmus no; Dukes no; Kerr yes; McIntosh no; Smith yes; Gosman no; Schuster no; Ingram yes; Petrich yes; Santare no; Hillis no; Clark no; Gattman no. A majority already registering a no vote, therefore, we wll not call the rest of the votes. The motion to remove from the table is lost.**

CHAIRMAN: At this time we will receive the reports of the trustees and any requests for remission of dues.

1st District: Dr. Wilhelmus: I have no report per se, but Dr. Corcoran and I did send out a questionnaire to the members of our district in regard to ISMA business and it has been quite enlightening. A great majority of the men in the area were against any change in the abortion law in Indiana. We are still compiling reports and I do not have any figures on the other questions.

2nd District, Dr. Dukes: No report.

3rd District, Dr. Kerr: No report.

5th District, Dr. McIntosh: I want to thank the trustees for attending a meeting in our fair city. I am sorry about the lack of participation of doctors from this district.

6th District, Dr. Smith: No report.

7th District, Dr. Gosman: No report. *Dr. Schuster:* No report.

8th District, Dr. Ingram: No report, but I would like to comment that I think our business is better conducted at our Headquarters in Indianapolis. I hope this does not offend anyone, but I think we do a better business in our own facility. I think we should be reluctant to accept invitations for this Board to meet outside Indianapolis.

9th District, Dr. Petrich: No report.

10th District, Dr. Santare: We have a meeting planned at the end of October at which Charles Findley will be the host. It will be a father-and-child affair and we extend an invitation to all the trustees to attend, if possible.

11th District, Dr. Hillis: The 11th District will meet September 23rd at the Holiday Inn in Wabash. The day is open for golf at the Wabash Country Club and the afternoon program will be a discussion on medical foundations. The dinner speaker will be Phil Eskew of IHSAA.

12th District, Dr. Clark: No report.

13th District, Dr. Gattman: Our District meeting was held in Elkhart on September 3rd. The afternoon program dealt with Foundations and the evening speaker was Congressional candidate Don Newman. I will report that I was re-elected Alternate Trustee from the district.

CHAIRMAN: We now have a resolution as it was approved by this body; Dr. Steen, would you do the honor.

DR. STEEN: **The motion to remove from the table having failed, I would like at this time to introduce a substitute motion. I move that the president be empowered to appoint an interim committee whose charge will be to investigate the relationships between the Indiana State Medical Association, between the several county medical societies, and between the individual members and Blue Shield, and to report back to the Board the results of their deliberations no later than six months from now.**

The motion was seconded by many and discussed by Dr. Schuster, Dr. Dukes, Dr. Ingram and Dr. Harshman.

CHAIRMAN: **The motion has been editorially amended to provide that the Board would peruse the names of the appointees to the commitee.**

The motion was further discussed by Dr. Hillis, Dr. Neumann and Dr. Steen.

CHAIRMAN: There being no further discussion, I call the question. All those in favor of the motion as amended, say "aye", opposed the same. **The motion was carried with Dr. Scamahorn voting no.**

We will now proceed to any old business. There being none, we are open for new business.

DR. SCAMAHORN: While at the communications meeting in Chicago last month, the AMA proposed an Institute on Leadership. It would be tailor-made, the basic course would be on communications, group dynamics, listening, logic, management theory, parlimentary procedure, problem solving and committee management. The program would be available after the first of January. I would like to be authorized to make contact with the AMA to come to our Headquarters and offer to the Board of Trustees, the Woman's Auxiliary Officers, and all the commission chairmen this course which, I think, would make them much more effective leaders. This would be at no cost to the individual and, by your approval, you would naturally pick up the expense, like a Board meeting for room and transportation, etc. **I therefore move that I be empowered to have a Leadership Training Seminar at our Headquarters sometime after the first of January.**

DR. WILHELMUS: What about county society presidents?

DR. SCAMAHORN: They would prefer not to go over thirty, preferably to keep the group around twenty-five. I think it would be great and I am for any means getting this type of course.

DR. HARSHMAN: What is the cost to the association on this?

DR. SCAMAHORN: The cost is just for the men who come down and their traveling expenses and since they are full-time employees of the AMA, their expenses will be paid by the AMA.

It was suggested that the program eliminate committee chairmen and that this be offered to the Board of Trustees, the Executive Committee and AMA delegates.

DR. HILLIS: **I would like to add the words "that adequate notice be given before this, so that proper arrangements can be made by those who would like to attend."**

CHAIRMAN: **The motion has been duly made, seconded with an editorial change. There being no further discussion, the motion was put to vote and carried.**

DR. STEEN: Point of information. If it is agreeable with the Trustees, in the appointment of the committee to evaluate the relationship between Blue Shield and ISMA, if I send you the names of the committee and a postcard for you to vote if you have objections, or if you approve the committee, so that this does not drag on indefinitely, please return the postcard. Unless there is an objection, this is the procedure I will use.

CHAIRMAN: I will read a resolution which has been presented for your consideration by Dr. Farquhar and his Emergency Medical Service Group.

"WHEREAS, continued improvement in emergency medical service remains an urgent need in our community, and

WHEREAS, city, county, and state governments have failed to participate effectively in the effort to improve the emergency medical services, and

WHEREAS, preparation of state legislation would bring these units of government into a coordinated effort with the health professions,

NOW THEREFORE, BE IT RESOLVED, that ISMA effect the passage f an act to provide a uniform, statewide mbulance program governing licensure of perators, equipment, good samaritan liability of protection to the operators, and continuing education program through ıe State educational system,

BE IT FURTHER RESOLVED, that ıis resolution be brought to the American Iedical Association to bring about similar ction in all the states."

)R. KERR: I move its acceptance.

HAIRMAN: The motion has been seconded by many. The motion was discussed y Dr. Ingram, Dr. Kerr, Dr. Petrich and)r. Steen.

)R. STEEN: Point of order. The Board ıay discuss this as much as they wish, ut this is not a matter of approval or isapproval. This is the resolution introuced by a commission over which we have o control whatsoever. We can give our pinion of this. We can say we don't like , but this resolution is in the hopper. is really an academic point. You don't eed a motion. This is just for information.

HAIRMAN: Dr. Kerr withdraws his otion.

R. WILHELMUS: **I would like to ıake a motion that in the future reorts from the Board of Trustees be ıbelled as coming from the Board of rustees instead of the Chairman of ıe Board.**

HAIRMAN: **I think we can take that y consent.**

There being no further business, the oard moved into Executive Session.

XECUTIVE COMMITTEE

October 12, 1970

The Executive Committee met at)0 a.m. Monday, October 12, 1970, in e Venetian Room, Randall's Inn, South end.

Roll call showed the following present: onald M. Kerr, M.D., Burton E. Kintner, .D., Lowell H. Steen, M.D., Malcolm O. amahorn, M.D., Peter R. Petrich, M.D., ester H. Hoyt, M.D., Hugh K. Thatcher, .D., Frank B. Ramsey, M.D., and James . Waggener.

Minutes of the meeting held September th were approved on motion of Drs. etrich and Steen.

Membership Report—The membership port as of September 30th was approved consent.

Membership Report as of September 30, 1970

Number of members as of December 31, 1969	4,482
1970 members as of September 30, 1970:	
Full dues paying members	3,939
Residents and interns	84
Board remitted	56
Senior	352
Honorary	3
Military	39
Total 1970 members as of September 30, 1970	4,473
Total 1969 members as of September 30, 1969	4,469
Number of AMA members as of December 31, 1969	4,330
1970 AMA members as of September 30, 1970	4,307
Full dues paying	3,773
Exempt, but active	534
	4,307
Number who have paid state dues but not AMA dues as of September 30, 1970	166
Number who paid state dues but not AMA dues as of December 31, 1969	152

Treasurer's Office

The report of the treasurer was approved on motion of Drs. Hoyt and Petrich.

Organization Matters

LETTER FROM GEORGE S. OLIVE CO.—A letter from the George S. Olive Company regarding inclusion of Auxiliary membership and the billing with membership dues for the ISMA was read and by consent was referred to the Board of Trustees.

CORRESPONDENCE DR. STEEN AND WELFARE DEPT.—Correspondence between President Steen and the State Department of Public Welfare concerning the request of HEW for the Department of Welfare to develop a list of providers of service to Medicaid recipients was reviewed and, on motion of Drs. Hoyt and Petrich, this was referred to the Board of Trustees.

REPLY FROM BUREAU OF MOTOR VEHICLES—A reply from the Bureau of Motor Vehicles concerning the physician certifying the ability of a patient to drive an automobile was read and, on motion of Drs. Petrich and Kintner, this was accepted as a matter of information and a copy of the letter to be referred to a Reference Committee of the House of Delegates.

LETTER FROM DR. BOWEN TO DR. STEEN—Correspondence between Dr. Bowen and President Steen was reviewed and, on motion of Drs. Petrich and Steen, this information is to be released to the press with Dr. Bowen's consent.

LETTER FROM THE AMA—A letter from the AMA seeking information on an Indiana physician as a member of the Committee on Maternal and Child Care was reviewed and the name was approved by consent.

LETTER FROM DEPARTMENT OF HEW—A letter from the Department of HEW concerning the new rules on deductibles of the Medicare program was reviewed for the information of the committee.

LETTER FROM DANIEL H. CANNON, M.D.—A letter from Dr. Daniel H. Cannon concerning the Retreat was read for the information of the committee.

MINUTES BLUE CROSS EXECUTIVE COMMITTEE—Excerpts from the minutes of the Blue Cross Executive Committee were reviewed for the information of the committee.

LETTER FROM STUDENT AMA—A letter from the Student AMA concerning the MECO project was reviewed and, on motion of Drs. Steen and Petrich, this matter was referred to the Board of Trustees.

SUBSCRIPTION TO MEDICAL NEWS REPORT—Renewal of the subscription to Medical News Report was approved on motion of Drs. Petrich and Steen.

GUIDELINES FOR PEER REVIEW—The secretary reviewed the guidelines for Peer Review as established by the Medical Association of Alabama and the review was taken as a matter of information.

SURVEY NATIONAL OPINION RESEARCH CENTER—A letter from the AMA concerning a survey to be done by the National Opinion Research Center was read for the information of the committee.

AMA NEWSLETTER—Excerpts from the AMA Newsletter of October 5th were reviewed for the information of the committee.

OREGON MEDICAL NEWSLETTER—The News Letter of the Oregon State Medical Society concerning a mail ballot for election of officers was reviewed for the information of the committee.

REQUEST OF DR. REID—The secretary reported that he had received a request from Dr. Robert Reid concerning the possibility of leasing space in the Headquarters building for his medical computer project. By consent, this matter is to be referred to the Board of Trustees.

RMP MATTER—Further discussion was held concerning the position of ISMA and the RMP program and this was deferred pending Board action.

CORRESPONDENCE FROM LAKE COUNTY—A letter from the Lake County Medical Society concerning mailing of Board actions to all members of the association was read and, on motion of Drs. Steen and Petrich, copies of this material will be made available in bulk to medical societies making such a request, with the responsibility for distribution being theirs.

Convention Matters

REPORT ON SALE OF EXHIBIT SPACE—The secretary reported that 59 spaces had been sold to exhibitors for a gross income of $14,200.

COLLEGE HEALTH PHYSICIANS' MATTER—The secretary asked clarification of previous action of the Board concerning honorarium and expenses for the speaker for the new Section on College Health Physicians and it was held that the association would pay $100 as honorarium only.

EXHIBITORS PARTY—On motion of Drs. Steen and Petrich, the secretary was instructed to hold a cocktail party for exhibitors at Randall's Inn on Tuesday evening, October 13th, at 6:00 p.m.

Legislative Matters

DECISION ILLINOIS SUPREME COURT—A decision of the Illinois Supreme Court holding that a blood transfusion constitutes a sale and not a service was reviewed for the information of the committee.

WIRE-CALIFORNIA MEDICAL ASSOCIATION—A wire from the California Medical Association concerning the Bennett amendment was read and, on motion of Dr. Steen and taken by consent, this is to be read to the Board of Trustees.

PRE-ADMISSION DIAGNOSTIC TESTING—A matter of Pre-Admission Diagnostic Testing was read for the information of the committee.

AMA LETTER S. 3418 FAMILY PRACTICE—A letter from the AMA concerning S. 3418 which creates an Advisory Council on Family Medicine and asking for nomination of representatives on the selection committee was reviewed and, on motion of Drs. Petrich and Kintner, it was voted to recommend Dr. Scamahorn for this position.

New Business

LETTER FROM JUDGE HAMILL—A letter was read from Judge Hamill concerning the delay in the case of the association against the State Board of Tax Commissioners. This was taken as a matter of information.

REQUEST FOR REFUND OF DUES—A request of an Indiana physician for a refund of dues, since he had left Indiana was refused by consent.

REPORT OF DR. KINTNER—Dr. Kintner reported for information only that the Elkhart County Foundation had met with the Blue Shield represenative and that tentative approval of a Foundation Plan for Elkhart County had been given.

RUSSELL SCHOLARSHIP PROGRAM—The president-elect read a letter concerning the establishment of a Russel Scholarship Program and, on motion of Dr. Scamahorn and Dr. Petrich, this matter is to be referred to the Board with a recommendation that the association offer mailing list and articles in the Journal to publicize the establishment of such scholarship program.

PRESIDENT'S ADDRESS—The president's address was reviewed and approved on motion of Drs. Petrich and Hoyt.

Future Meetings

A notice of a Conference of Physician' Assistants to be held at Duke University in Durham, N.C., was deferred on motion of Dr. Petrich and taken by consent.

A notice of the AMA Conference on Rural Health to be held in Atlanta, Ga. in March of 1971 was deferred until a future meeting.

A notice of a meeting of the American College of Legal Medicine to be held in New Orleans in May of 1971 was deferred until a later meeting.

There being no further business, the committee adjourned to meet again on November 14th.

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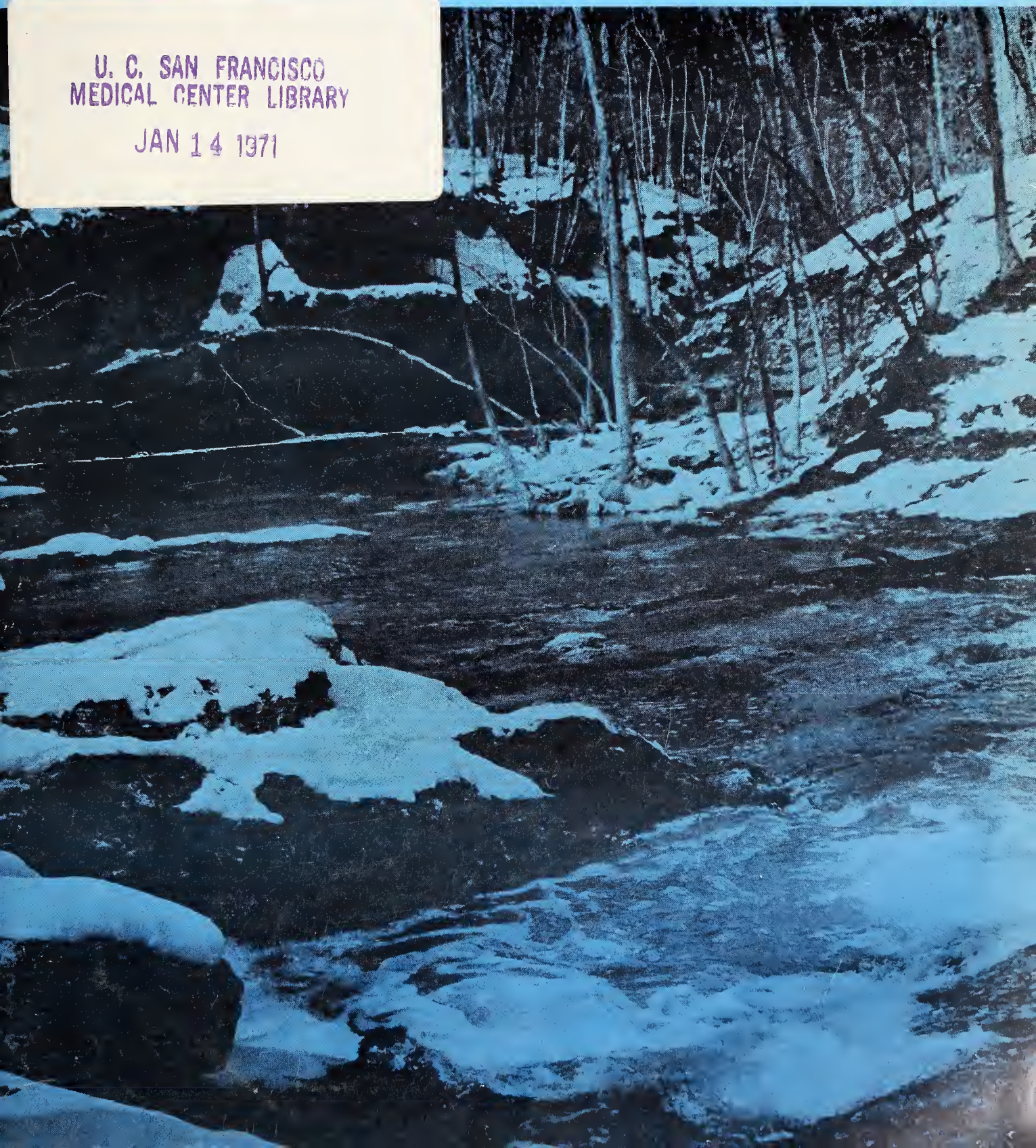
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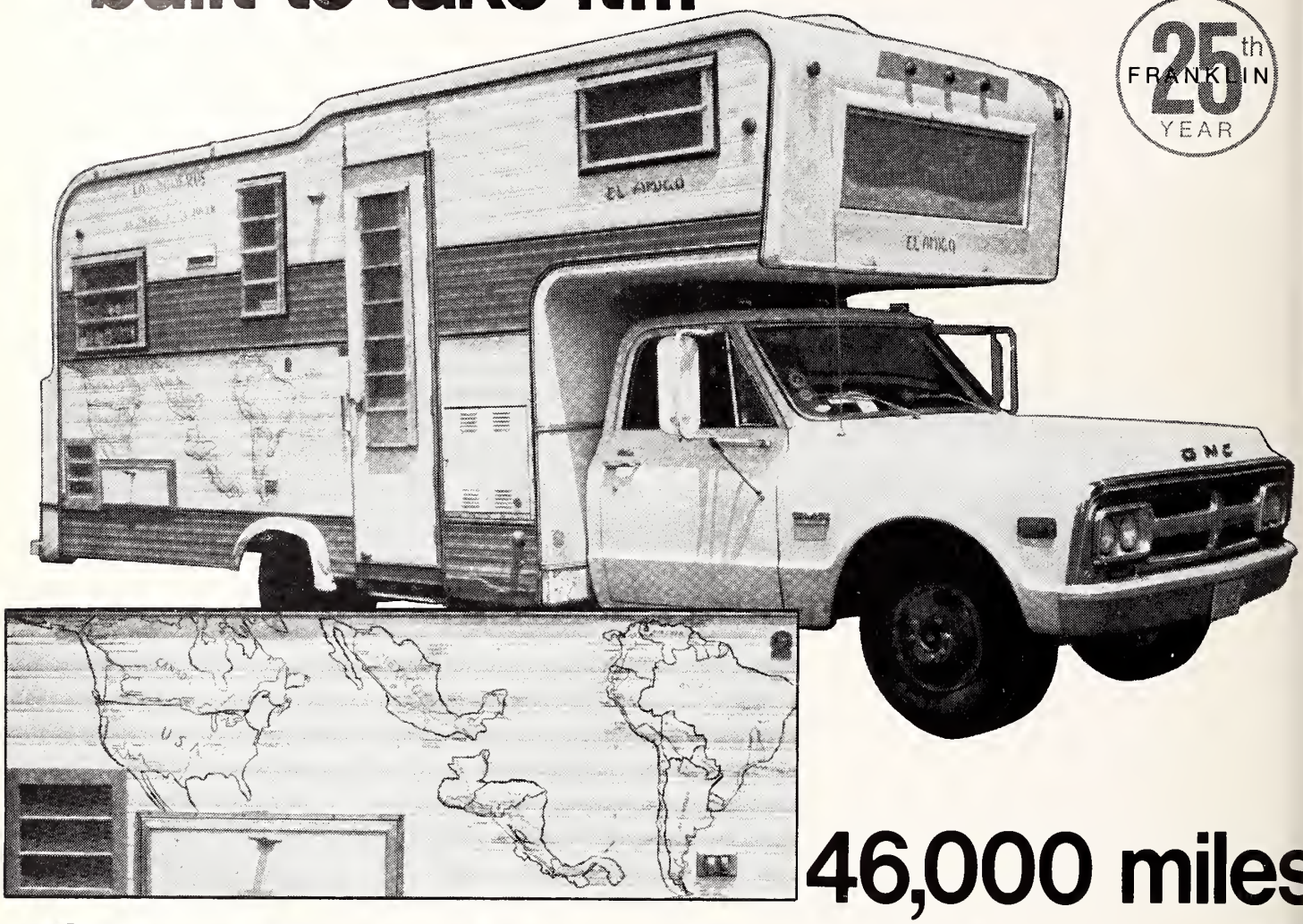
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(1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: NY State Jour. Med., 58:2672-2673, August 1958. (6) Ellis, S. and Spratt, J. S.: JOUR. AMER. GER. SOC., 18:410-415, May 1970.

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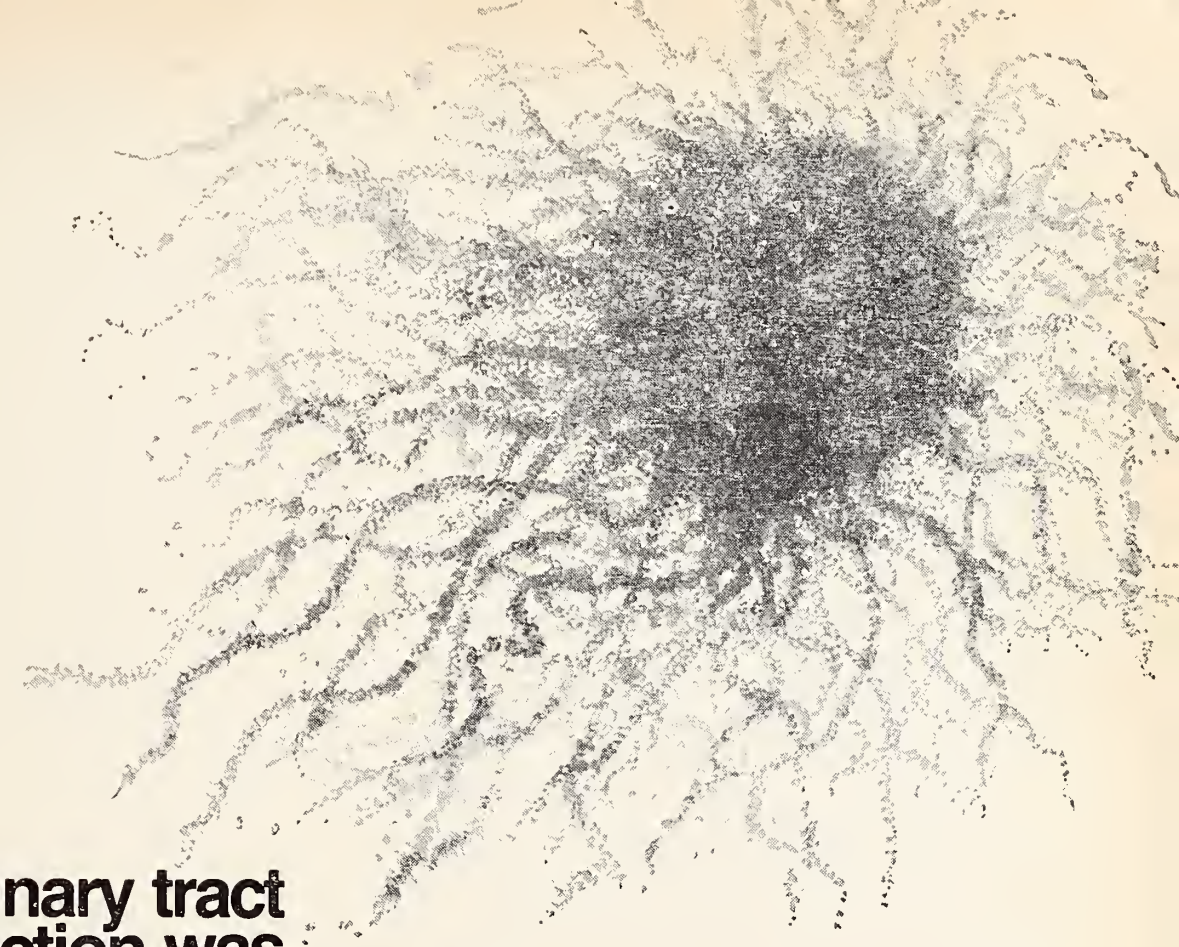
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District	Term Expires
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Eugene F. Senseny Fort Wayne	Eugene S. Rifner Van Buren
Frank H. Green Rushville	Kenneth O. Neumann Lafayette

Terms expire December 31, 1971:

Delegates	Alternates
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John Farquhar Fort Wayne	Thomas C. Tyrrell Hammond

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2.	Thomas O. Barrett, Vincennes	J. S. Brown, Carlisle	Washington
3.	Daniel H. Cannon, New Albany	Elmer L. Wallace, New Albany	
4.	Gordon S. Fessler, Rising Sun	Fred D. Houston, Lawrenceburg	May 19, 1971
5.	William G. Bannon, Terre Haute	James W. Cristee, Terre Haute	
6.	David Wynegar, Richmond	John Moenning, Greenfield	May 5, 1971, Greenfield
7.	Ellery T. Drake, Martinsville	Donald E. Stephens, Indianapolis	Martinsville
8.	Eugene M. Gillum, Portland	Ralph E. Schenck, Portland	June 2, 1971, Portland
9.	James M. Kirtley, Crawfordsville	Wesley E. Shannon, Crawfordsville	
10.	Lambro Dimitroff, Hammond	J. M. Siekierski, Griffith	
11.	Lloyd C. Hill, Peru	Fred Poehler, La Fontaine	Peru
12.	George C. Manning, Fort Wayne	William B. Hughes, Waterloo	May 19, 1971, Fort Wayne
13.	Frank J. McGue, Michigan City	John Hildebrand, South Bend	



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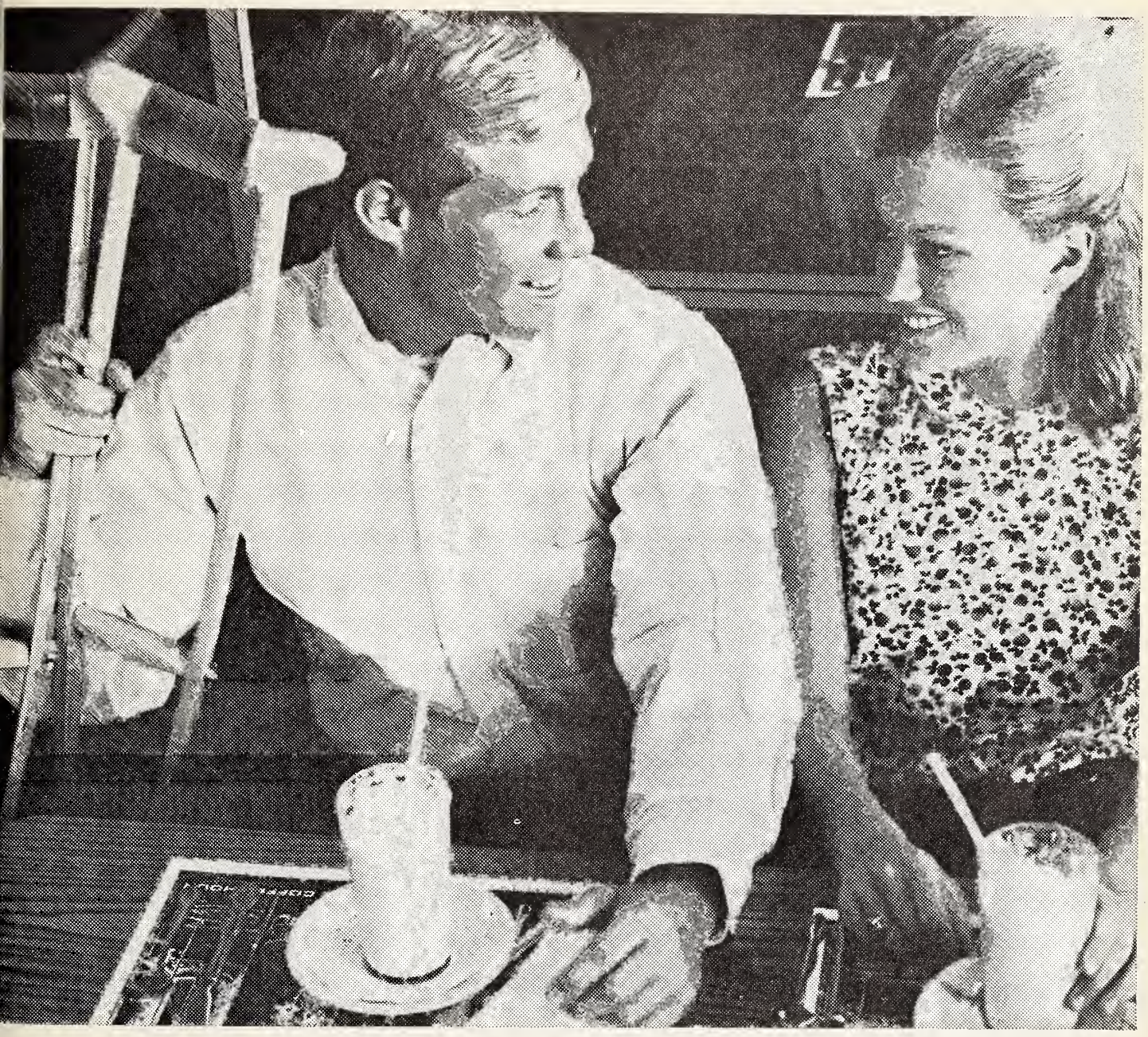
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December 1970

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The concert was just underway,
When to the conductor's dismay
Cramps and diarrhea,
Did so quickly appear,
The maestro no longer could stay.

Because diarrhea with cramping, nausea, and painful straining can strike at the most inopportune time, it takes a comprehensive agent to treat the total diarrheal syndrome and help get the patient back on the job. That's why so many physicians rely on Donnagel, especially during the fall and winter months when "flu" and viral gastroenteritis usually hit their peak.

Donnagel is much more than just a simple kaolin-pectin combination. It also contains the belladonna alkaloids to calm GI hypermotility and help relieve the distressing discomforts which so often accompany diarrhea. Certainly it's less expensive and more convenient than taking two medications. And the dosage is lower too. Available in the handy 4-oz. plastic bottle at pharmacies everywhere on your prescription or recommendation.



When diarrhea and its discomforts separate a man from his job . . .

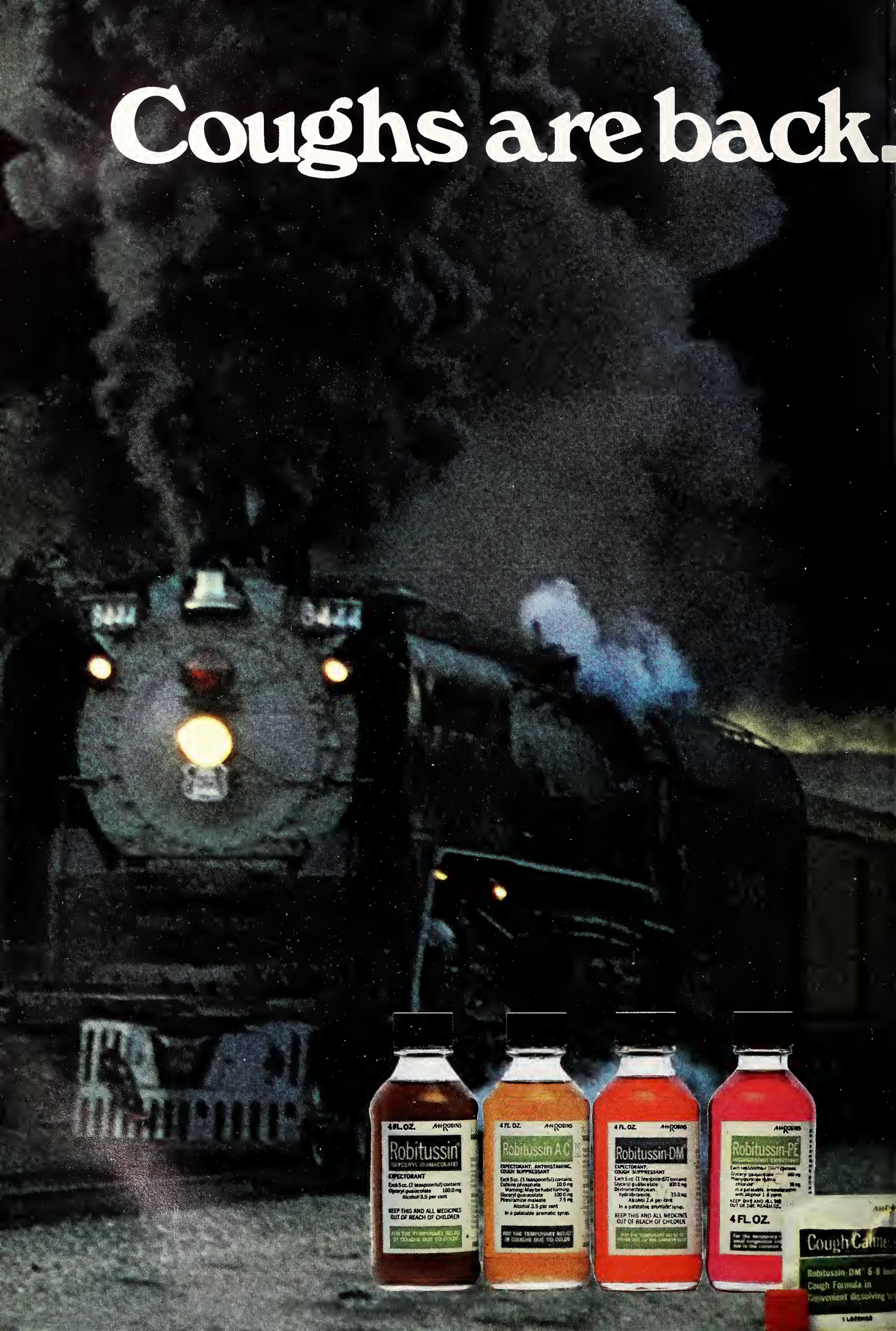
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Each fluid ounce contains: Kaolin, 6 g.; Pectin, 142.8 mg.; Hyoscyamine sulfate, 0.1037 mg.; Atropine sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.; Sodium benzoate (preservative), 60 mg.; Alcohol, 3.8%.

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For coughs of colds and "flu"

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Each 5 cc. contains:

Glyceryl guaiacolate	100.0 mg.
Alcohol, 3.5%	

For unproductive allergic coughs

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(warning: may be habit forming)	
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Non-narcotic for 6-8 hr. cough control

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Each 5 cc. contains:

Glyceryl guaiacolate	100.0 mg.
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Clears sinuses and nasal stuffiness as it relieves cough

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Robitussin-DM in solid form for "coughs on the go"

Cough Calmers™

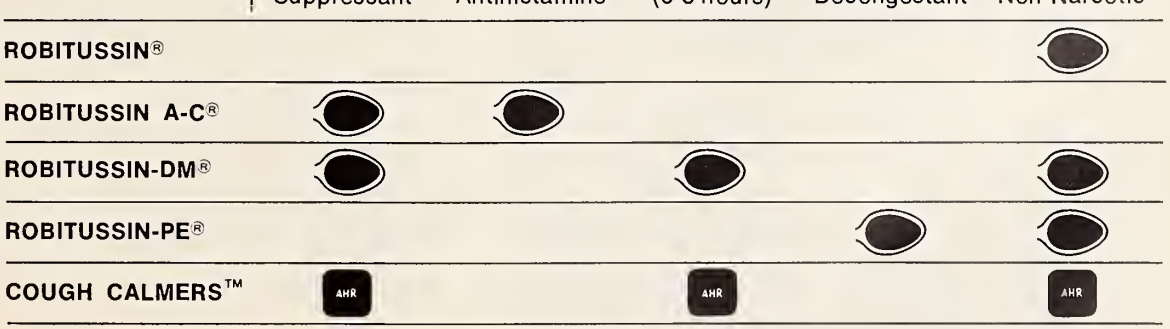
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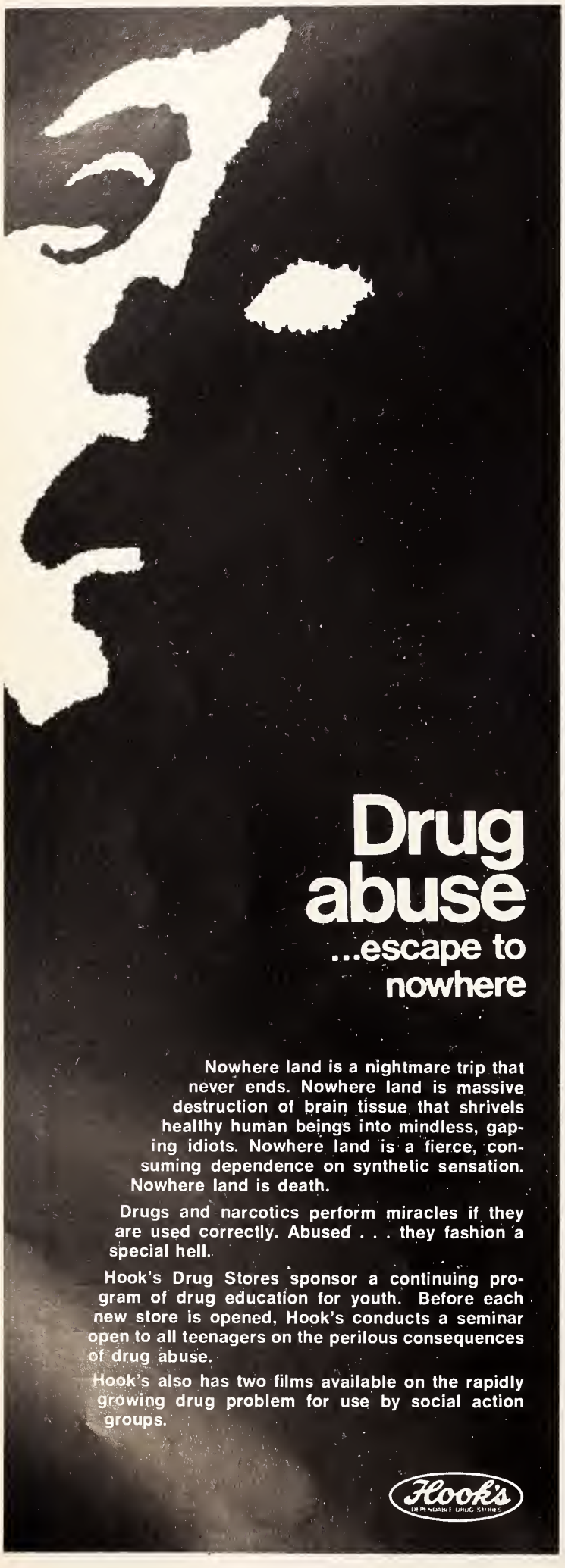
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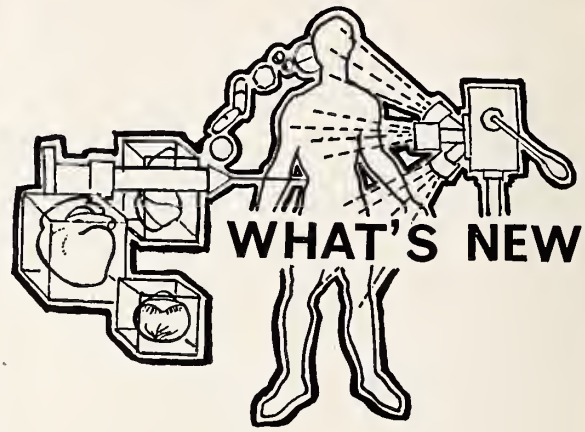
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WHAT'S NEW?

The biggest trouble with diets is the lack of desserts. Desserts are usually rich in fat and/or sugar. Help for dieters comes in the form of a Doubleday book, "Delicious Diet Desserts." 168 pages for $4.50, it contains more than 100 delectable dessert recipes that cut calories without sacrificing taste appeal.

* * *

Mead Johnson is introducing a new unit dose packaging of Colace in two dosage forms, Peri-Colace and Quibron Capsules. The individualized packaged unit doses are economical, in that time is saved in dispensing. Medication errors are reduced since each dosage form is identified.

* * *

Charles Scribner's Sons has released a book by William D. Poe, M.D., entitled The Old Person in Your Home. Dr. Poe is a geriatrician of many years' experience who provides sensible and sympathetic answers to the many vexing questions that arise with the elderly. It is written in nontechnical language for nonmedical people who are responsible for or who have aged persons in their home. The book is also good reading for physicians who care for the older group.

* * *

Dr. Frank G. Slaughter's fifty-first novel, Surgeon's Choice, has recently been released by Doubleday. According to the release, it is a cogent argument for drastic changes in medicine. It concerns the plan of a brilliant transplant surgeon in an "outdated" clinic for the rebuilding of the facility into the most modern medical outfit on earth. Price $5.95.

* * *

Mead Johnson has announced that ProSobee, its soy isolate formula, is now offered in 32-ounce cans of Ready-To-Use formula, the first such formula available in this convenient form. Previously ProSobee was sold only in 12-ounce cans of Concentrated Liquid.

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.



MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

THE AMERICAN Medical Association challenged charges of widespread tax cheating by physicians and renewed its offer to cooperate with the government in cracking down on dishonest doctors.

IN LETTERS to Sen. Russell B. Long (D., La.), chairman of the Senate Finance Committee, Walter C. Bornemeier, M.D., president of the AMA, answered the tax cheating charges and Ernest B. Howard, M.D., executive vice president of the AMA, renewed the offer of cooperation. But Howard also said that mandatory reporting of unassigned fees by insurance agencies would be an ineffective and unfair way to try to uncover doctors cheating on their income taxes on payments for their services under medicare and medicaid.

THE TAX-CHEATING charges grew out of testimony given by Meade Whitaker, who then was tax legislative counsel for the Treasury Department, at a hearing of the Senate Finance Committee during its consideration of changes in the medicare and medicaid programs. He said that many providers of services under the two health care programs might have "substantial deficiencies" in their income tax returns.

IN A LETTER to Long and Sen. Wallace F. Bennett (R., Utah), a ranking minority member of the finance committee, Dr. Bornemeier said that the charges had been widely distorted in the press and these reports do the medical profession a serious injustice.

WHITAKER testified that from an original list of 11,000 who received payments of $25,000 or more for services rendered under medicare and medicaid in 1968, 4,000 returns warranted a detailed audit by the IRS.

WITH PRELIMINARY audits completed on 3,000 of the 4,000 returns, there were indications that 1,500 of these showed "substantial deficiencies," the Treasury reported. "Substantial deficiencies" later were defined as being underpayments of more than $100.

DR. BORNEMEIER said that this testimony was being widely interpreted to mean either that one-third of the medical profession was cheating (4,000 of 11,000 cases to be audited) or that one-half of the profession was cheating (1,500 alleged offenders from 3,000 actual audits).

"ASSUMING the worst — that 1,500 doctors out of 11,000 are guilty of income tax irregularities — the correct proportion would be between 13 and 14 per cent rather than 33 or 50 per cent," Dr. Bornemeier said.

THE AMA president called on the Treasury Department to be specific in its

PUBLISHED TO REPLACE A PREVIOUS ADVERTISEMENT WHICH THE FOOD AND DRUG ADMINISTRATION CONSIDERED MISLEADING

The Food and Drug Administration has requested that we bring to your attention a recent promotional campaign for Garamycin Injectable (gentamicin sulfate) which featured a nationwide *in-vitro* hospital survey involving a comparison of sensitivity patterns of Garamycin Injectable and seven other antibiotics.

The FDA considers the advertising misleading in several respects such as:

The *in-vitro* chart contained in the ads, which compared Garamycin Injectable with seven other antibiotics, implied that Garamycin Injectable is clinically more effective than the seven other compared antibiotics. THE FACTS ARE (1) THAT DIRECT EXTRAPOLATION OF NONCLINICAL FINDINGS TO CLINICAL EFFECTIVENESS IS UNWARRANTED, AND (2) THAT THE ADVERTISED *IN-VITRO* COMPARISONS DO NOT CONSTITUTE A VALID BASIS FOR SUGGESTING THAT GARAMYCIN INJECTABLE HAS GREATER CLINICAL EFFECTIVENESS THAN THE COMPARED ANTIBIOTICS.

The *in-vitro* chart and information contained under the ad heading, "Indications" presented *in-vitro* data results in such a way as to imply that the drug is indicated for Gram-positive bacteria, such as *Staphylococcus aureus.* GARAMYCIN INJECTABLE IS NOT APPROVED FOR INFECTIONS DUE TO ANY GRAM-POSITIVE ORGANISMS.

We emphasize that Garamycin Injectable is approved for use only in infections due to susceptible strains of gram-negative bacteria, including Pseudomonas aeruginosa, and species of indole-positive and indole-negative Proteus, Escherichia coli, and Klebsiella-Aerobacter.

Injectable Garamycin®

brand of gentamicin sulfate injection

Schering

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

BRIEF SUMMARY

INDICATIONS GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including Pseudomonas aeruginosa, and species of indole-positive and indole-negative Proteus, Escherichia coli, and Klebsiella-Aerobacter. Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly Pseudomonas aeruginosa, Proteus and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

CONTRAINDICATIONS GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

WARNINGS Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

PRECAUTIONS In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentration of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

ADVERSE REACTIONS The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

PACKAGING GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

SCHERING CORPORATION, UNION, NEW JERSEY 07083

SCH-2620

charges since the interpretation by the press growing out its testimony reflected on the profession as a whole.

"AS OF NOW," he continued, "there seem to be 1,500 cases where substantial deficiencies may exist. I think we should know what proportion of these cases represents cause simply for further examination and what proportion represents cases that may realistically be expected to end up with the fraud division of the IRS.

"I THINK we should know what proportion of the serious cases involve physicians. I suspect the figures given include osteopaths, dentists, pharmacists and optometrists and others eligible to receive medicare-medicaid payments."

DR. BORNEMEIER told Long that his request for documentation of these cases was not a defense for the dishonest physician or anyone else who attempts to falsify an income tax return.

"WE ARE on record," the Chicago physician said, "as requesting examples of wrongdoing by doctors receiving payments under government health programs so that we may take action of our own."

DR. HOWARD said that "the dishonest or incompetent physician hurts us just as much as he harms his government."

DR. HOWARD said that a recent statement by Long that the AMA had been "completely forthright and honorable, and sought to shield no one" is "exactly our position."

THE AMA official also noted that Long at a recent hearing of the finance committee had referred correctly to previous requests by the AMA that it be given examples of suspected chicanery by physicians in government health programs "so that we might take our own action."

AS FOR mandatory reporting of unassigned medical payments — those given to the patient rather than to the physician — Dr. Howard said such a requirement "would not provide the Internal Revenue Service with helpful and meaningful data." He urged rejection of such an amendment proposed by the Treasury Department. A joint House-Senate conference committee rejected it last year in considering tax reform legislation.

THE TREASURY Department proposed that Blue Cross-Blue Shield organizations, medicare and medicaid agencies, and other health insurance carriers be required to report unassigned payments for medical services.

DR. HOWARD pointed out that millions of patients have more than one health insurance policy and may collect total benefits exceeding the physician's charge, and that some patients even may not use the insurance payment to compensate the physician. Physicians also would have to set up costly additional bookkeeping record procedures to list separately and in detail each charge to a patient in excess of $25, the AMA official said.

"THE PROPOSAL of the Treasury Department would place physicians in a unique category under our tax laws," Dr. Howard said. "We know of no other provision in the tax laws which singles out one class of individual taxpayers, requiring payers to report to the IRS individual payments made to taxpayers as well as the annual aggregate amount of such payments.

"WE BELIEVE . . . that the proposed . . . amendment is unfair and discriminatory and would do little to accomplish any goal for an improved system. Instead, as an additional cost burden, it would place further pressure on the cost of medical care."

PRESIDENT PRAISES DRUG ABUSE ACT

PRESIDENT NIXON, at a bill-signing ceremony, praised the new Drug Abuse Act for providing "a forward looking program" for treatment of drug addiction as well as strengthening the government's law enforcement powers in the field.

THE NEW law provides for the Department of Health, Education and Welfare running extensive programs for the treatment and rehabilitation of drug users and for antidrug education. It authorizes HEW's National Institute of Mental Health to spend $189 million over three years to build and staff treatment facilities, to support rehabilitation programs and to increase antidrug education programs. Another $1 million is authorized for creation of a presidential commission on marijuana.

STATE comprehensive health plans getting federal aid must now include drug abuse programs, and an Administration spokesman suggested that all states model their drug control laws on the federal statute.

BEFORE final passage, Congress modified the original legislation to meet many of the objections of the medical profession against a proposal that would have allotted most classification powers and research control to the Justice Department. The attorney general can declare drugs as dangerous but he is bound by HEW's medical and scientific evaluations.

THE STRENGTHENED enforcement provisions are aimed at the drug pusher with lighter penalties for drug possession, particularly by minors. Federal first offense cases for drug users are lowered from felonies to misdemeanors. Under this provision, a person found guilty of possessing marijuana for the first time will not necessarily be subjected to an automatic stiff jail sentence. But to facilitate arrest of pushers, the controversial "no-knock" clause was retained.

REQUIREMENTS as to records kept by physicians remain as under the old narcotics law except where he regularly dispenses a non-narcotic drug and charges for it.

THE NEW law broadens the former narcotics statute to include, with varying restrictions and controls, amphetamines, barbiturates and other drugs ruled dangerous. At the start, controls will be drastically tightened over marketing the liquid form of amphetamines which can be taken by injection.

COMPANIES producing or distributing a long list of commonly prescribed stimulants, depressants and tranquilizers will be subject for the first time to federal registration requirements. The Narcotic Bureau also now has a new power to set production quotas for such non-narcotic drugs.

. JOSEPH STETLER, president of the Pharmaceutical Manufacturers Association, praised Congress and the Administration for enactment of the law: "DRUG abuse has become a frightening problem for millions of Americans. It is absolutely proper for the federal government to exercise this type of aggressive leadership to stem the use of physically and psychologically damaging illicit substances, to control the misuse of legitimate medicines produced for the health and welfare

Continue

of citizens and to support rehabilitative needs for victims of the drug problem."

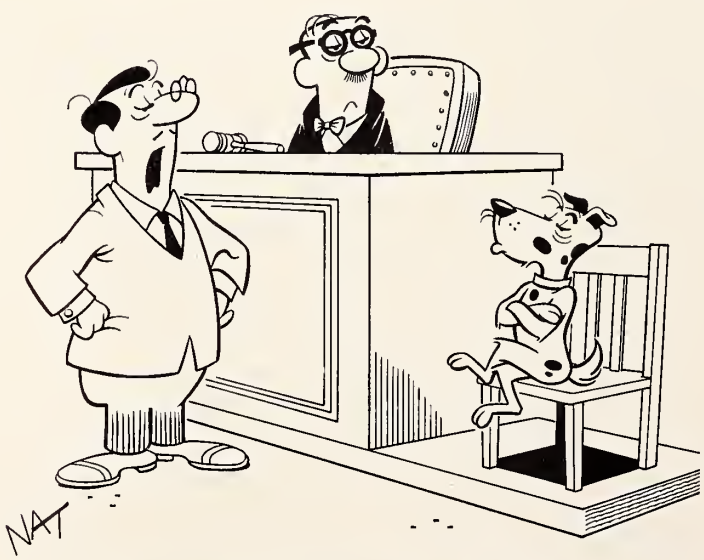
OTHER HEALTH legislation recently enacted into law included:

—THE COMMUNICABLE Disease Control Act of 1970 which authorizes expenditure of $21 over the next three years for vaccination and other control programs against tuberculosis, venereal disease, German measles, measles, polio, diphtheria, tetanus, whooping cough, RH disease and other diseases judged by the Secretary of Health, Education, and Welfare to be major problems.

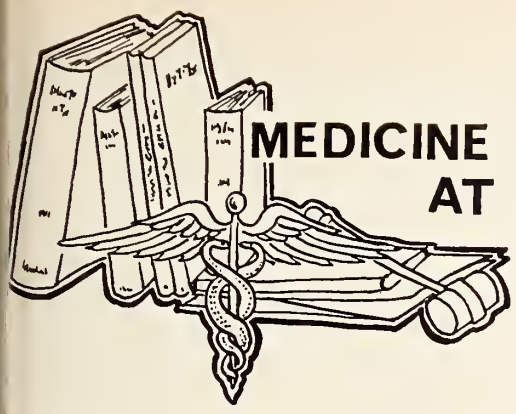
—THE REGIONAL Medical Programs and Comprehensive Planning and Services Act of 1970 extending the programs for three years with authorized spending of $545 million for RMP and $52 million for CHP. Further appropriations totalling $961.5 million for project grants for areawide health planning; training, studies and demonstrations; comprehensive public health services, and health services development. RMP is expanded to include kidney disease. The new law provides for a systems analysis of national health care plans and for a cost and coverage report on such legislation. A National Advisory Council on Comprehensive Health Planning Programs is created.

—THE HEALTH Training Improvement Act of 1970 which extends the allied health educational program for three years with aid to schools and students. Authorized appropriations total $308.5 million. The maximum yearly loan will be $1500 and the maximum aggregrate loan $6,000 for any student. A forgiveness of up to 50 per cent will be allowed if the student practices in a shortage area or for a nonprofit organization after graduation.

—THE DEVELOPMENTAL Disabilities Services and Facilities Construction Amendments of 1970 extending the mental retardation facilities construction program for three years and expanding it to include grants for planning, provision of services, and construction and operation of facilities for persons with developmental disabilities. Authorized appropriations total $295 million.



We're not interested in your opinions, just answer the question!



MEDICINE AT LAW

Malpractice Panel Decision Held Binding on Patient—A patient who had started suit against his physician for malpractice and later agreed to submit his claim to a medical subpanel for a binding decision could not revoke his consent after the subpanel decided against him, the New Jersey Supreme Court ruled.

Under court rules, written consent to be bound by the subpanel's decision barred legal proceedings on the claim. The patient claimed that the rules had a coercive effect and were invalid.

The rules in question provided that the claimant might agree in writing to submit his case to a medical subpanel and to dismiss his suit if the subpanel were of the opinion that there was no reasonable basis for his claim. If, however, the subpanel found there was a reasonable basis, the claimant would be supplied with the names of three expert medical witnesses, from a list compiled by the Medical Society of New Jersey, who would serve at a reasonable fee.

On the other hand, if the claimant did not wish to be bound by the decision of the subpanel, the parties could still agree to a hearing before the subpanel. However, the claimant, in the event of a favorable decision, would not be entitled to the services of the expert medical witnesses.

After filing suit, the patient requested a non-binding medical subpanel hearing. The physician refused to consent unless the patient agreed to be bound by the subpanel's decision.

Some months later, the patient agreed. After a hearing had been held, as well as a rehearing which had been requested by the patient, the subpanel decided there was no reasonable basis for the patient's claim.

The patient refused to dismiss his suit, as agreed, claiming that he was forced to accede to the binding hearing under duress by the physician. He contended that the effect of the court rules was coercive.

The court ruled that the patient had entered into the agreement with full knowledge of the terms and could not withdraw consent after an adverse decision. The judgment of the trial court dismissing the patient's suit was affirmed.—*Grove v. Seltzer*, 266 A.2d 301 (N.J. Sup. Ct., June 23, 1970).

Physician Liable for Death Due to Post-Surgical Embolism—Damages in the amount of $90,000 were awarded by a jury for the death of a fracture patient who suffered a massive pulmonary embolism the day after his discharge from the hospital. Suit was brought by the patient's family against the hospital, the attending physician, the orthopedist, and an internist. The damage award was against the attending physician only.

The patient had sustained a fracture dislocation of the ankle, which required an open reduction and pin fixation. Approximately eight days after the surgery the patient suffered shortness of breath, right chest pain, and raised right diaphragm. A marked clockwise rotation of the heart was revealed by an EKG. There was testimony that the pulmonary embolism traveled from near the fracture site into the right lower lobe of the lung.

An internist who testified for the patient's family stated that the embolism was a danger signal which should have alerted the attending physician to administer an anticogulant on the day the symptoms appeared. It was the internist's opinion that the patient should have been kept hospitalized, rather than released two days after the attack.

The surgeon who performed the autopsy testified that the clot broke loose from the right femoral vein above the fracture and was pumped through the right side of the heart up to the bifurcation of the pulmonary artery, where it lodged. The clot occluded both pulmonary arteries, causing sudden death. The attending physician, the internist who interpreted the EKG, the orthopedist who performed the surgery, and the hospital were named in the suit.

The physicians contended that a pulmonary embolism or the clotting of blood is difficult to detect under the circumstances that existed. They urged that the proper standard of care had been met by all of the physicians and the hospital.

The suit was dismissed as to the internist and the hospital, and the jury was instructed to return a verdict in favor of the orthopedist on the ground that there was no expert testimony showing that he violated any standard of due care.

It was claimed that funeral expenses and loss of income totalled $89,500. After the jury returned the $90,000 verdict against the attending physician, a motion for a new trial was filed.—*Souza v. Moline* (Cal. Super. Ct., Stanislaus Co., Docket No. 97990, 1970).

Patient Recovers Damages for Removal of Kidney—A verdict in the amount of $100,000 was returned by a California jury in favor of a

patient who alleged that his physician was negligent in treating a kidney ailment. It was claimed that the kidney became infected after the removal of a stone and that the physician unnecessarily removed the kidney.

The physician contended that the kidney was diseased and that its removal was necessary in order to save the patient's life. He further urged that the man was in poor health prior to the surgery, due to mistreatment in a Nazi prisoner-of-war camp.

It was claimed that the patient's out-of-pocket expenses were $9,000. After the jury returned the $100,000 verdict, the physician moved for a new trial.—*Pilersky v. Conroy* (Cal. Super. Ct., San Mateo Co., Docket No. 140275, 1970).

Physician Liable for Blood Loss after Biopsy—A patient who suffered bleeding after a biopsy won a suit against a gastroenterologist and a clinic for negligence in performing the procedure and in "coverage" following it. An award of $25,000 was handed down by a California jury.

The patient, a 36-year-old teamster, suffered bleeding from the site of a rectal valve biopsy performed by the gastroenterologist.

As a result of the blood loss, complete cardiovascular collapse occurred, which was relieved by transfusions. The physician denied negligence and insisted that the bleeding was from preexistent ulcerative colitis.—*Hatam v. Babb* (Cal. Super. Ct., Santa Clara Co., Docket No. 214055, 1970).

Physicians Liable for Patients' Amphetamine Addiction—Three men who allegedly suffered complete loss of earning capacity as a result of becoming addicted to amphetamines given them as treatment for business pressures were awarded $320,000, $105,000, and $10,000, respectively, by a California jury.

An insurance underwriter, an attorney, and a contractor were treated over a period of about five years with injections of what they said were described to be vitamins plus a relaxant. They contended that the injections were actually amphetamines of various kinds, to which they became addicted to the extent that they could no longer carry on their businesses.

The physicians, nurse, laboratory technician, and distributor of the drugs, all named in the suit, contended that the men were not given any addictive drugs, that they assumed the risk when they took the injections, and that they were not addicted to any drugs given by the accused medical personnel.—*Stevens v. Keyser* (Cal. Super. Ct., Orange Co., Docket No. 141832, 1970).

Malpractice in Hospital Recovery Room—A widow whose husband died after alleged improper treatment in a hospital's recovery room following uneventful surgery received a settlement of $100,000 after she filed suit against the hospital, physicians, and a medical group.

The husband, a laborer, had slipped while digging a trench. He went to a medical center, where a diagnosis of hernia was made. The patient was admitted to a hospital, and surgery was planned for the following day.

The operation was uneventful, and the attending anesthesiologist reported that the patient was taken to the recovery room in good condition. About 15 minutes later, the recovery room nurse noted that the patient was not breathing and that no pulse or blood pressure was observable.

A cardiac arrest team was called immediately. Resuscitation was attempted with positive pressure oxygen and external massage. Then an injection of Adrenalin was given and the patient was connected with a pacemaker. There was immediate recovery of normal cardiac function. However, convulsive seizures commenced, and the patient was given treatment in the intensive care unit. A tracheotomy was performed, but the patient died about six days after surgery. Death was attributed to terminal bronchopneumonia due to lateral sinus thrombosis.

The widow contended that her husband was given improper doses of anesthesia during surgery and was not properly supervised by recovery room personnel. She said that the patient had a period of anoxia in the recovery room because his airway was not kept open and because the recovery room nurse failed to detect signs of beginning cyanosis. She further contended that the patient's heart was strong before the surgery, that he was a good operative risk, and that the resumption of normal cardiac output following the emergency indicated a strong and vital heart.

The hospital contended that death was caused by cardiac arrest of unknown mechanism following surgery. The patient had some degree of coronary arteriosclerosis, the hospital said, and either a reaction to medication or the stress of surgery triggered the cardiac arrest. It was further contended that lack of cardiac output resulted in cerebral anoxia with eventual death.—*Gonzalez v. Studebaker Community Hospital* (Cal. Super. Ct., Los Angeles Co., Docket No. SE C7137-S, 1970).

Liability of Hospital for Flash Fire Injuring Patient—Even if a patient were smoking while under oxygen therapy, a hospital may be liable for injuries incurred as the result of a flash fire, a Georgia appellate court ruled.

A coronary patient brought suit against the hospital because he suffered severe burns as the result of a flash fire which occurred while he was being given oxygen therapy. The hospital filed affidavits indicating that the equipment was in good working order, and it moved to dismiss the case before trial. The trial court denied the motion. On appeal, the reviewing court considered the evi-

dence set forth in the depositions and affidavits filed by both sides and affirmed the decision of the trial court.

A witness for the patient stated that the oxygen machine was noisy and that it vibrated and became hot. Experts who testified for the hospital stated that the equipment was in good order and that there was no evidence of burns on the wiring or the motor.

The hospital contended that the fire was the result of smoking by the patient. The patient said that he was not instructed to refrain from smoking, although a nurse stated to the contrary.

Since the evidence was in dispute, the petition of the patient stated a cause of action, the appellate court said. Therefore, it was not error to deny dismissal of the case.

The court noted that if the patient had set the fire by striking a match, it was possible that the hospital was negligent in failing to observe the patient properly while under oxygen therapy.—*Elberton-Elbert County Hospital Authority v. Watson*, 174 S.E.2d 470 (Ga. Ct. of App., Feb. 11, 1970; rehearing denied, April 1, 1970). ◀

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 63 — December 1970 — Number 12

Endarterectomy dissection by means of gas has been found to be a simple, rapid and gentle method of removing obstructing intimal plaques.

Gas Endarterectomy in Carotid Stenosis

MICHAEL W. MANZIE, M.D., F.A.C.S., F.I.C.S., D.A.B.S., F.A.C.A.
GEORGE ROWE, M.D., General Surgery Resident
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Introduction

THE long term beneficial effect of carotid endarterectomy in stroke prevention is well established.[4] However, controversy continues concerning the technical aspects of carotid endarterectomy.[1,2] This controversy is based on how to prevent the cerebral ischemia that occasionally results from the operation itself. The utilization of the technique of gas endarterectomy, a rapid and nontraumatic procedure, prevents cerebral ischemia.

Materials and Methods

Eight carotid gas endarterectomy procedures have been performed on seven patients since September 1968. The age range was 42 to 71 years with an average age of 62 years. There were four males and three females. All patients gave a history of symptoms of cerebral vascular insufficiency verified by physical examination (which included 50%-plus carotid stenosis on arteriographic evaluation).

The carotid gas endarterectomies were performed under general anesthesia, administered by endotracheal intubation using halothane. Either hypercarbia, accomplished by controlled hypoventilation and removal of the carbon dioxide absorbent, or acetazolamide, given intravenously in a half to one gram dose, was used. Systemic heparinization was achieved by administration of 50 to 100 mgms of aqueous heparin intravenously. If bradycardia or hypertension developed, with carotid bifurcation manipulation, 1.0% lidocaine was infiltrated into the area.

The common carotid artery is exposed by an incision along the anterior edge of the sternomastoid muscle. After the artery is occluded proximally and distally by tapes, carbon dioxide is introduced into the adventitia anteriorly, laterally, and posteriorly, through a 25-gauge needle which is attached to a tank of carbon dioxide. A rate of flow of between 20 liters and 30 liters per minute is maintained. The vessel is then opened longitudinally and the central core, including the intima, is removed. Closure of the arterial incision is by 6-zero or 7-zero monofilament plastic suture.

The carotid blood flow was totally occluded during the procedure in two patients; in six patients the carotid blood flow was shunted. In the first two patients the arteriotomy was closed without an internal shunt. In the other six patients, the arteriotomy was closed with an internal shunt. The average occlusion time was 10 minutes without the shunt and three minutes with the shunt.

Comments

Our investigation of gas endarterectomy, as an adjunct in arterial reconstruction, followed its introduction by Sawyer et al.[9] and other investigators.[7,10] Our experience confirmed that the carotid is particularly adaptable to this technique. The carotid bifurcation is easily exposed and mobilized. The segment of carotid artery involved is 6 - 8 cm. long, optimal for application of this technic, and the entire circumference is accessible for injection. In contradistinction to other vessels, bleeding is not a problem with good side branch control.

Blaisdell et al.[4] assessed the technical results of carotid endarterectomy in a hundred patients by routine operative arteriograms. An unsuspected intraluminal defect or thrombosis was demonstrated in 25% of patients. On immediate re-exploration, a defect in repair was found. These authors stressed the importance of being meticulous.

* From the Department of Medical Research, Methodist Hospital Graduate Medical Center, Indianapolis 46202.

In performing carotid arterial reconstruction by the usual methods, the adventitia is frequently contused by the surgeon. Inadvertent tears or perforations are made in attempts to find the proper endarterectomy plane. The adventitia is frequently ragged because several planes have been created. Gas endarterectomy is a non-traumatic procedure. A natural plane is obtained, there is minimal handling of the adventitia, a smooth clean adventitia remains and the distal end of the artery is frequently tapered eliminating a distal intimal flap.

A shunt was not used in the first two patients; the patient who developed transient cerebral ischemia in the immediate postoperative period had a total occlusion time of 13 minutes. With the use of an internal shunt, average occlusion time was about three minutes. The argument that a good endarterectomy cannot be done because the shunt is cumbersome is not valid if the shunt is utilized only during arteriotomy closure.

Sufficient evidence is not available to warrant performing carotid endarterectomy under local anesthesia in preference to general anesthesia.[1,2] The use of systemic heparinization, hypercarbia or acetazolamide, and internal bypass shunt assures an excellent technical adjunct during carotid endarterectomy to prevent intraoperative cerebral ischemia because of the speed with which the procedure can be performed.

Summary

Seven patients with transient cerebral ischemia attacks have been treated with carotid gas endarterectomy. Six are improved or asymptomatic, one patient with mild preoperative hemiparesis is unchanged, one patient in whom a bypass shunt was not utilized developed a transient hemiparesis in the immediate postoperative period. There have been no other complications. A follow-up arteriogram is available in one patient (Fig. 1).

We believe gas endarterectomy to be expeditous in performing carotid artery reconstructions. It is a simple, rapid, gentle technique. The immediate results in this small series of patients have been good and the long term effectiveness should be as satisfactory as other reported series.

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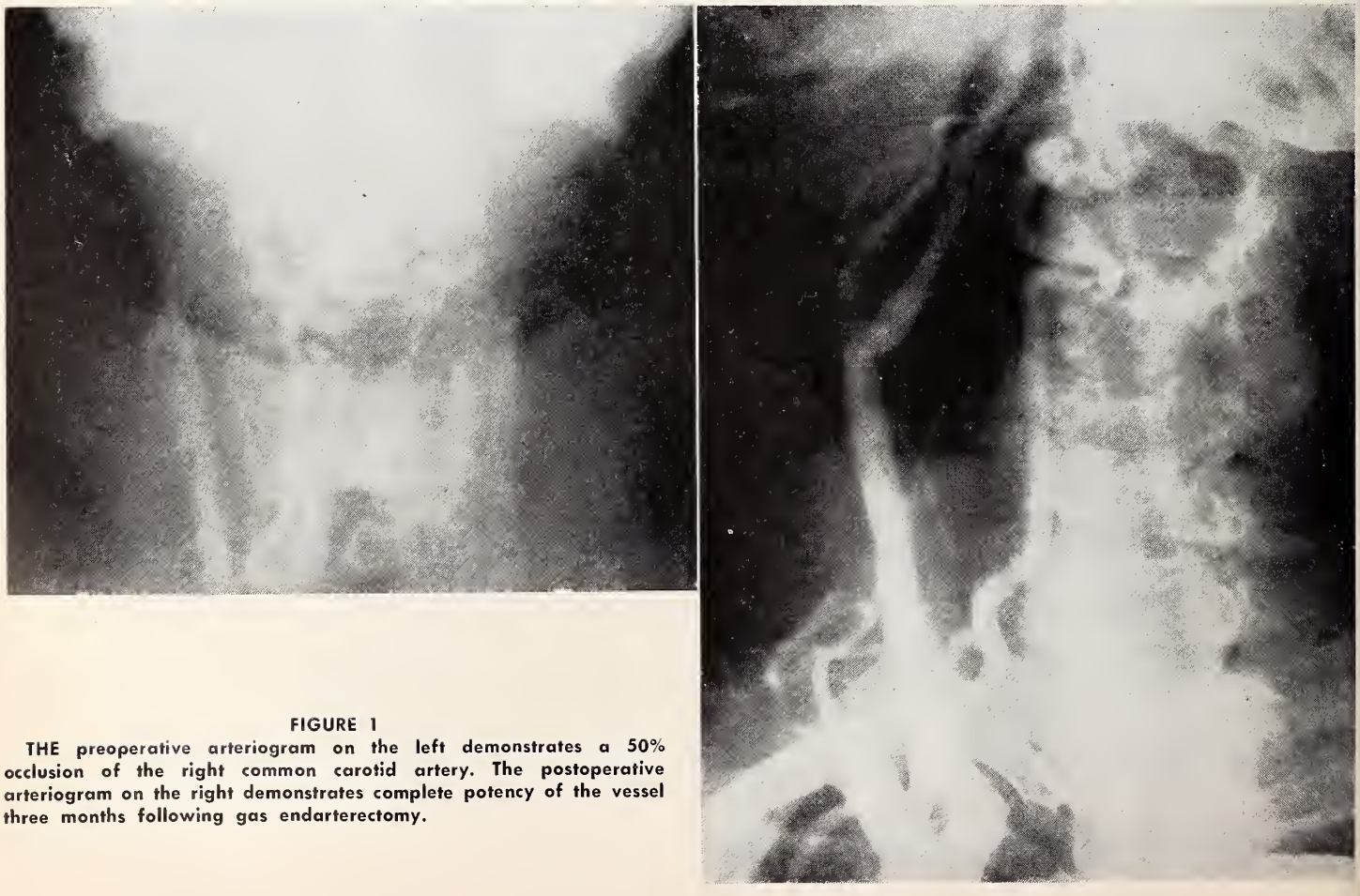


FIGURE 1

THE preoperative arteriogram on the left demonstrates a 50% occlusion of the right common carotid artery. The postoperative arteriogram on the right demonstrates complete potency of the vessel three months following gas endarterectomy.

A Simple, Inexpensive Aerosol Generator

JACK M. KAMEN, M.D.*
Gary

SOME authors have demonstrated the effectiveness of bronchodilator aerosols in the treatment of chronic obstructive airway disease.[1,2] No distinct advantage of administering the aerosol by an intermittent positive pressure breathing apparatus (I.P.P.B.) over a simple aerosol generator has been shown.[3] The I.P.P.B. equipment has the disadavantages of high cost (usually over $150) and the complexities of assembly and administration. Portable hand nebulizers, whether powered by an inert gas or by a squeeze bulb, are prone to be overused. The period of aerosol production is very limited and is much less than the normal inspiration time. Because of this, they do not fit in well to a home therapy regimen.

Recently the Mead Johnson Company introduced the MAXI-MYST aerosol apparatus. Its total cost is approximately $50. It consists of a motor driven air compressor, a length of tubing, and a nebulizer. The tubing has an optional side port that must be occluded to send the air flow through the nebulizer (Figure 1).

The nebulizer is usually held two to four inches from the opened mouth and the aerosol inhaled (Figure 2).

Although the unit was originally designed for use with acletylcysteine, we have found it to be quite effective in the administration of bronchodilator aerosols.

Because of the preponderance of elderly patients requiring treatment, a bronchodilator compound that does not require mixing or dilution was used. This requirement was met by Aerolone Compound (Lilly) consisting of cyclopentamine hydrachloride, and isoproterenol in a propylene glycol base.

Some of the patients had difficulty inhaling the mist when the nebulizer unit was held as recommended. They were unable to accurately direct the mist into their mouths and to coordinate inspiration with the onset of nebulization. This was overcome by using a disposable plastic mouthpiece modified to fit on the proximal end of the nebulizer and having the patient breathe through it.

Two 3/8-inch ports were drilled on opposite sides of the mouthpiece. A scissors was then used to make slits from the distal end of the mouthpiece to the ports (Figure 3). The patients were then able easily to self-

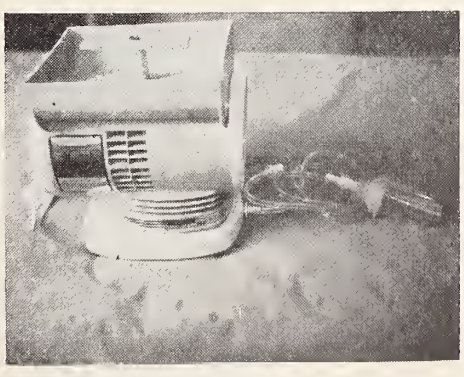


FIGURE 1

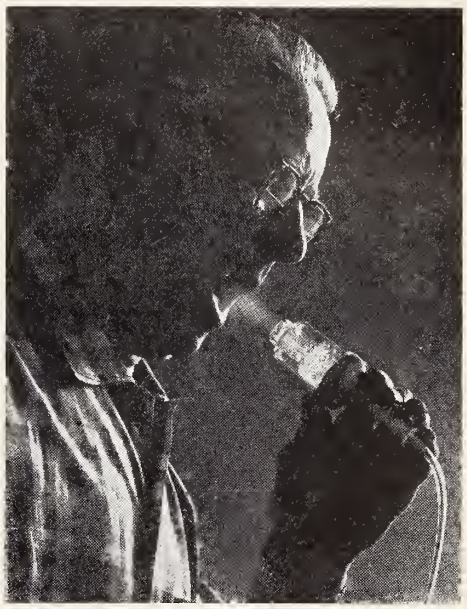


FIGURE 2

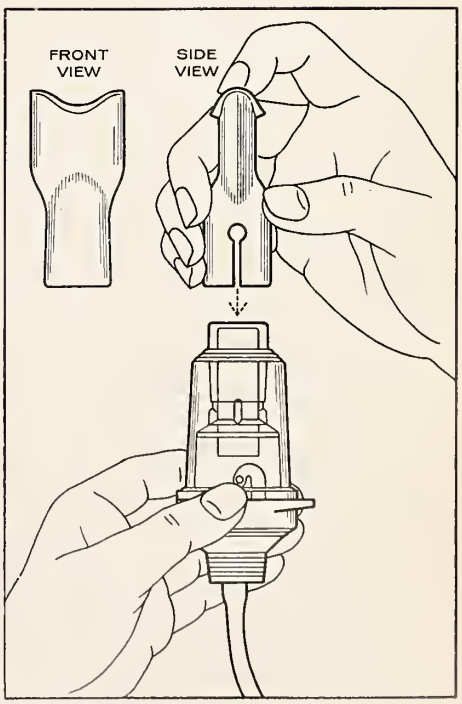


FIGURE 3

* Assistant Professor, Department of Anesthesia, Northwestern University Medical School; Director of Inhalation Therapy Department, St. Mary Mercy Hospital, Gary.

administer the medication (Figures 4 and 5).

The rare child who needs home aerosol therapy (enzyme administration in a patient with cystic fibrosis) finds this technique of administration quite easy.

The particle sizes nebulized were found to be as follows:

		With Mouthpiece	Without Mouthpiece
Weight % particles	$<1\mu$	16.5	15.5
	$<2\mu$	31.7	30.9
	$<5\mu$	71	67
	$<10\mu$	94	93
Mass median diameter		3.2μ	3.5μ

The particle size distribution curves are essentially the same, with or without the mouthpiece.

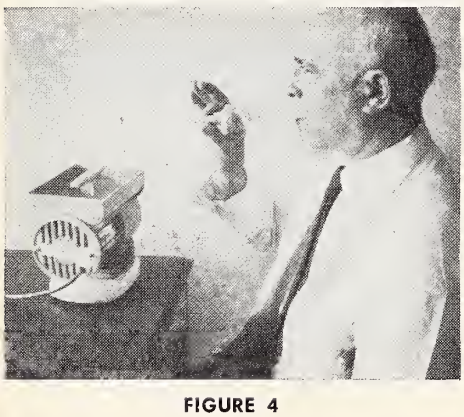


FIGURE 4

Determinations of weight loss per minute of nebulization produced the following data:

	With Mouthpiece	Without Mouthpiece
Weight loss/min.	0.0807 g	0.1723 g
" " "	0.0815 g	0.1538 g
" " "	0.0812 g	0.1378 g
Average weight loss/min.	0.0811 g	0.1548 g

It is apparent that when the MAXI-MYST nebulizer is fitted with the mouthpiece, the delivery of Aerolone Compound Solution is reduced to approximately one-half. Since the aerosol is more accurately delivered, no compensation is made.

Electrical safety and durability were not tested by the author.

Acknowledgments

The author wishes to thank Dr. A. F. Muskovitch of Mead Johnson and Company for the particle analysis.

Ben Millman, A.R.I.T., supervisor, Inhalation Therapy Department, Saint Mary Mercy Hospital, posed for the photographs in Figures 4 and 5.



FIGURE 5

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Malaria: A Persistent Problem for Civilian Physicians in 1971

JACKSON G. CROWDER, M.D.
*Indianapolis**

WITH the return to the United States from Southeast Asia of housands of American soldiers early, civilian as well as military physicians have been faced with the liagnosis and treatment of diseases ndemic to Southeast Asia. One of he major diseases of this type has been malaria.

Types of Malaria

The majority of cases of malaria occurring in servicemen in Viet Nam re due *to Plasmodium falcipaum* (1). Most of the remainder are lue to *Plasmodium vivax*. When maaria occurs in servicemen who have eturned to this country, *P. vivax* is ound in the majority of cases. This would be expected considering the iology of the *Plasmodia*. *Plasmodum vivax* has a prolonged exorythrocytic phase (2). Therefore, elapses may occur up to 2½ years fter leaving an endemic area. *Plasnodium falciparum* has no such prolonged exo-erythrocytic phase.

These facts are illustrated in the elative incidences of vivax and falciparum malaria seen at the Veterans Administration Hospital in Indianapolis. There have been 50 patients with malaria in the past 3½ years. Vivax malaria was found in 43 of these patients, and falciparum malaria in only 3. The species was not identified in the remaining patients.

Clinical Findings

Most patients with vivax malaria have shaking chills and fever. Fever often occurs daily instead of in the classical tertian or quartan pattern. The liver and spleen may be palpable. Slight scleral icterus may be noted, reflecting the hemolysis that occurs in malaria. Fever in falciparum malaria usually occurs daily. However, falciparum malaria frequently does not present in the classical manner. Patients may present with gastrointestinal complaints, musculoskeletal complaints, postural hypotension, irrational behavior, or delirium. It should be emphasized that malaria should be considered in the differential diagnosis in any ill individual who has been in an endemic area. Thick and thin blood smears should be obtained for examination by someone competent in interpretation of these smears.

Prophylaxis

All troops in Viet Nam take one combined chloroquine-primaquine tablet once weekly as prophylaxis. This tablet contains 300 mg of chloroquine base and 45mg of primaquine base and is effective in suppressing vivax malaria. In addition, in some areas of Viet Nam, 25mg daily of diaminodiphenyl-sulfone (dapsone) is also given for suppression of falciparum malaria. When servicemen return to this country, they are issued eight chloroquine-primaquine tablets to be taken once weekly. They also take one dapsone tablet daily for 28 days. In many cases, emergence of clinical disease after return to this country is due to failure to take prophylactic medication.

Treatment

Vivax malaria is effectively treated with the combination of chloroquine and primaquine. Chloroquine is effective against the erythrocytic phase and primaquine against the exo-erythrocytic phase of *P. vivax*. The total dose of chloroquine phosphate is 2.5gm (1.5gm base) given as 1.0gm initially, 0.5gm in 6 hours, 0.5 gm on the second day, and 0.5 gm on the third day. Primaquine phosphate, 26.3mg (15mg base), is given daily for 14 days. This regimen will result in radical cure in over 90% of patients.

Falciparum malaria is considerably more difficult to treat. The majority of strains from Southeast Asia are resistant to chloroquine and primaquine. The current regimen com-

* From the Indiana University Medical Center Indianapolis, Indiana 46202.

bines the use of three drugs. Quinine sulfate, 650mg, is administered three times daily for 10 days. Pyrimethamine (Daraprim), a folic acid antagonist is given in a dosage of 25mg twice daily for three days. Dapsone, 25mg daily, is given for 28 days. Dapsone is a sulfone which is also used in treatment of leprosy.

Plasmodium falciparum parasitizes red blood cells of any age, unlike *P. vivax* which involves mainly young red cells. Therefore, an extremely high percentage of red cells may be parasitized in falciparum malaria. This makes falciparum malaria a more dangerous disease, with complications such as cerebral malaria, pulmonary edema, blackwater fever, and acute renal failure (3). These complications may develop with marked rapidity. Patients with falciparum malaria should be transferred to a hospital with facilities to treat these complications.

Potential in the Civilian Population

Malaria in an American who has not been in an endemic area is rare. However, species of anopheline mosquitoes capable of acting as malaria vectors are widespread in this country. There have been several cases of malaria in the past several years in persons who had not been in endemic areas. Significantly, most of these persons lived near military installations, in one instance as close to Indiana as Ft. Campbell, Kentucky.

Malaria can be transmitted by transfusion of blood from an infected person (4). It is recommended that a person who has had malaria not be permitted to donate blood, and that a person who has been in an endemic area not be permitted to donate blood for at least two years after leaving the endemic area.

Finally, prior to 1940, malaria was a well known disease in addicts, transmitted from person to pe son by use of communal needle With the current increase is illic drug use in this country, malari should be considered along with othe infections in the differential dia nosis of fever in addicts.

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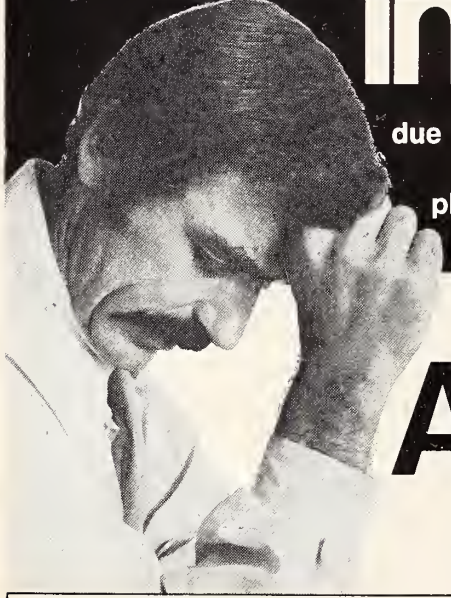
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Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
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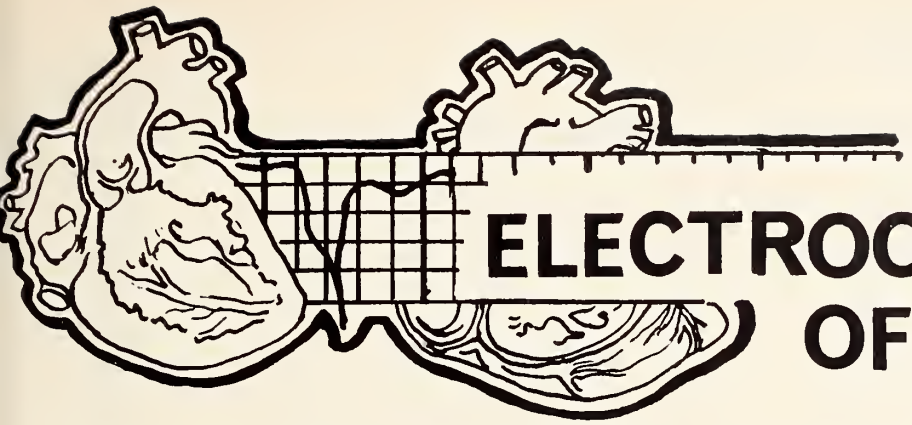
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ELECTROCARDIOGRAM OF THE MONTH

Myocardial Infarction: Ventricular Tachycardia

CHARLES FISCH, M.D.
*Indianapolis**

Ventricular tachycardia (VT) is a common and one of the more serious complications of myocardial infarction (MI). In the CCU setting the arrhythmia is easily recognized and treated.

Figure 1 demonstrates classical ECG features of VT, the aberrant QRS not related to P waves and accurate coupling to preceding normal P-QRS complex in presence of repetitive VT (rows 2-6). This tracing is unusual because of alternation of the amplitude of the T wave. This arrhythmia responded to a 70 mg bolus of lidocaine, followed by an intravenous infusion of the drug at a rate of 1 mg per minute. Although most instances of VT complicating MI will respond to lidocaine, occasionally the VT may be resistant and other drugs need be used.

Figure 2 is an example of VT complicating MI which was resistant to lidocaine but responded promptly to a slow infusion of 1.0 gm of procaine amide and on a different occasion to infusion of potassium at a rate of 0.5 mEq per minute. Other drugs which may prove useful include quinidine and propranolol and, in emergent situations, the procedure of choice is cardioversion.

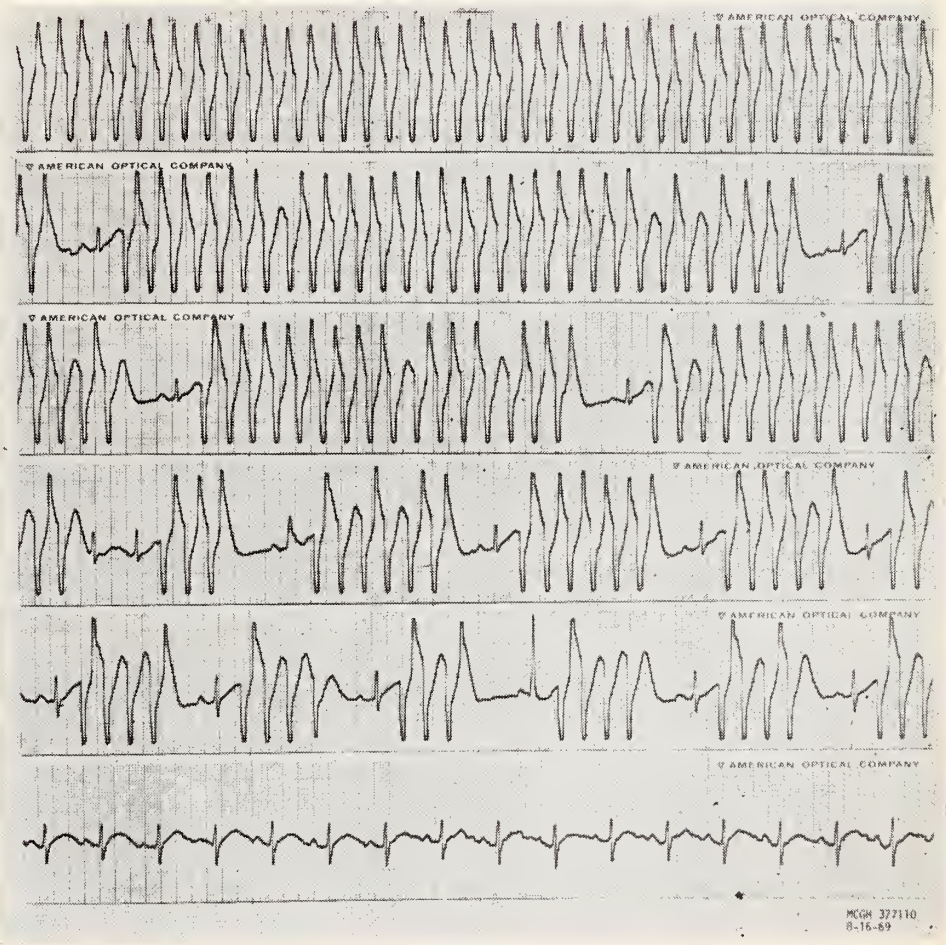


FIGURE 1

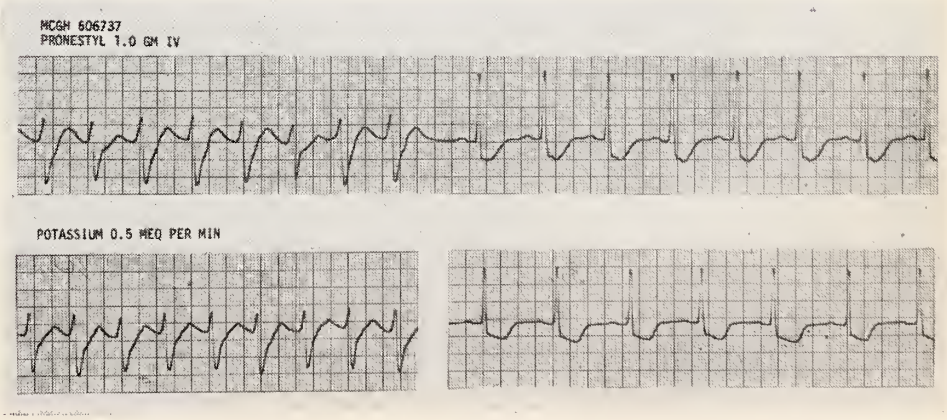


FIGURE 2 →

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—October 1970

Disease	Oct. 1970	Sept. 1970	Aug. 1970	Oct. 1969	Oct. 1968
Animal Bites	908	845	1175	890	687
Chickenpox	109	26	20	191	130
Conjunctivitis	173	127	125	86	54
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	36	37	55	4	23
Gonorrhea	817	754	753	739	497
Impetigo	326	243	190	285	183
Infectious Hepatitis	42	41	52	70	33
Infectious Mononucleosis	117	61	29	89	82
Influenza	1176	543	338	870	890
Measles					
Rubeola	1	5	5	3	15
Rubella	70	57	60	75	64
Meningococcic Meningitis	1	0	3	6	1
Meningitis, Other	3	7	2	7	1
Mumps	117	63	63	127	105
Pertussis (Whooping Cough)	23	15	14	7	13
Pneumonia	379	198	220	230	189
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	715	512	418	564	368
Syphilis					
Primary & Secondary	36	21	34	38	32
All Other Syphilis	139	103	114	97	117
Tinea Capitis	6	5	5	16	9
Tuberculosis (Active)	102	65	70	70	80

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It Seems So Foolish

THE politicians cry for more preventive medicine when what we need is more people to take advantage of what preventive measures are now available and are not used.

There is little rationale in providing more preventive medicine when only about 1% of what is now provided is actually used.

The American people are popularly supposed to be greatly interested in good health when, as a matter of fact as demonstrated by their behavior, they have only an impertinent interest in the health of everyone else, and will do nothing for their own personal health. This is in the great majority of instances.

To be sure, if everyone could pay $10.00 and have a good fairy like Elizabeth Montgomery twitch the nose and produce perfect health for the rest of their lives, the offer would be universally accepted. However, only a precious few will discipline themselves to accomplish the basic good health status of normal weight, sufficient exercise, abstinence from tobacco and avoidance of traumatic death.

Most of our citizens are interested in preventive medicine and good health if someone else produces its benefits. Very few people are interested in their own welfare enough to work for it. The individual practice of preventive medicine involves self denial of many pleasant but slightly harmful parctices. This is where the great American public fails the test. All are interested in good health only if it can be achieved without any personal sacrifice.

There are at least three great public health problems in the United States the avoidance of which and the cure of which do not require the advice of a doctor of medicine, nor even the knowledge of a college graduate. Most moderately bright children in the tenth grade could probably outline the cause and cure of these diseases.

Suicide by eating too much, suffocation by cigarettes and homicide by careless auto driving are three diseases that are typical of what the American public thinks of preventive medicine. They don't want any of it and will not use it when it is available.

It seems so foolish for anyone to promote more preventive medicine when what we have is not utilized. We do not need more prevention—we need some means of influencing everyone to take advantage of what we have already.

Guest Editorials

Growing Pains

SOme thirty years ago, a system of health and hospital insurance was born. We as a profession helped to launch this program and have cooperated in its development. At the present time, this "Third Party" system of prepaid health care threatens to destroy our traditional methods for the delivery of health services.

So popular has this idea of health insurance become, that labor unions negotiate for it with management and politicians promise it to their constituents. The citizens of this country now realize that health insurance of some type is a necessity if the costs of these services are to be paid.

During the years of health insurance evolution our economy has inflated. Hospitals have been able to meet these increased costs by regularly renegotiating their charges with the insurance industry. Physicians have suffered this same increase in costs in the operation of their offices, thus necessitating the increase of our professional fees for service. It is at this point that we as a profession find ourselves in this evolution of events.

Insurance carriers have been reluc-

tant to increase "allowable" fees for our services. Usual and customary, basic or minimum fee schedules have been paraded in front of us as a guide for our acceptance for our services. Since these allowances have been unrealistic and have lagged far behind the costs of other services in the general economy, the patient, who must pay the difference between what his insurance company allows and what our fee actually may be, concludes that the doctor is overcharging. This erroneous deduction is one of the factors which has contributed to the altered image of the physician in the eyes of the public today.

The time has come to stop yelling "foul!" and start taking aggressive action in these matters. A system must be developed whereby insurance carriers and the medical profession can sit down together at regular intervals to update allowable fees to a more realistic level. Our only alternative is to have professional negotiators at the bargaining table when these matters so vital to us are being decided.

In the days of Abraham Lincoln the bartering of a person's services without his permission was called slavery.—**Donald E. Stephens, M.D.,** *The Marion County Medical Society Bulletin*, October, 1970. **Reprinted by special permission.**

Dangerous Discoveries

IT is a truism that the discovery of each new substance with any kind of biologic activity will be accompanied by some sort of biologic threat to the earthly microcosm. The new substance may be an insecticide which indirectly damages birds' eggs, or new antibiotics which might lead to the selection and development of threatening mutant strains of bacteria.

Similarly, every time the clinician develops a new artificial situation which markedly affects patients, an immediate search should be made for adverse effects. In some instances the adverse effects may not only threaten a patient, but his physician as well. An example of this thesis is the dangers associated with renal dialysis and the secondary effects of immunosuppression for the patient and indirectly the attending staff. Dangers to the patient include electrolyte abnormalities, peculiar alterations of hormonal balances, obscure adverse effects on the hematologic system, susceptibility to infection, and even psychologic effects which are difficult to measure. An extreme illustration of the danger to such patients treated by immunosuppression is the threat of undetected cancer cells in the transplanted kidney and the development of new cancers from the patient's tissues. As immunosuppression by chemicals and antilymphocyte globulin reduces the natural surveillance mechanisms—probably lymphocytes—abnormal cells can apparently gain a foothold, grow, and then generate their own antigenic material which may further neutralize defense mechanisms. There are informal reports of the development of over 25 malignancies in relatively young patients treated with immunosuppression measures for a brief period of a few years. One might expect that other diseases in which cellular immunity plays a major role will also develop in such patients. For example, latent tuberculosis may become activated and these patients are probably more susceptible to infections with fungi and certain viruses.

Outbreaks of hepatitis are extremely common in patients undergoing renal dialysis. They are exposed to multiple blood transfusions and have a reduction of normal defenses. It has been noted that often times the course of this disease is not as severe in patients under immunosuppression, probably because the antibody-antigen-tissue reaction is also suppressed. This result is not unlike the amelioration of certain virus diseases in newborn animals without mature immune reactions. The situation is one which would allow the tissues to produce large amounts of virus.

Unfortunately, such outbreaks of hepatitis provide a major threat to the staff members in such units, and the number of nurses and physicians who have developed severe and even fatal hepatitis has become a problem of major importance. It is clear that immediate steps must be taken to protect the staff members of such units and that the casual visitations of such units by relatives and hospital staff members must be stopped. The unit should be separated from hospital activities and appropriate warnings of "Biological Hazard" be posted. Apparently the prophylactic treatment of the staff members of dialysis units with gamma globulin has not been effective, but a vigorous assessment of the dangers of this prophylactic treatment has not been made. From a medical-legal standpoint, it would seem wise that all medical centers inform prospective employes in such units of the dangers associated with them and that, if possible, blood samples be obtained before employment so that the levels of the AU-SH antigen be detected. Perhaps only persons with positive AU-SH antigenicity should be employed.

One hopes that more strenuous efforts will be made to separate renal dialysis units from the normal exchange of hospital traffic, and that proper isolation technics plus separate air discharge be used.

These episodes again remind us that there is a biologic price to pay for each new development of a biologic active substance or procedure. —*New York State Journal of Medicine*, Oct. 1, 1970. **Reprinted by special permission.**

Dr. Myers Responds For 50 Year Club Members

(At the President's Luncheon in

South Bend on October 15, Dr. Roy V. Myers of West Palm Beach, Fla., formerly of Indianapolis, spoke on behalf of the 1970 inductees.)

IT is certainly an honor to be asked to respond for this year's Fifty Year Club. There are twenty-five of us enrolled in the club this year. There are 9 present at this meeting.

I think I can speak for all of these doctors when I say that we are grateful to have reached this milestone in our careers. Many haven't made it. Also we are grateful that during these fifty years we have had the privilege of observing the tremendous advance in scientific and technical medicine. When we began our careers the practice of medicine was mostly an art. Now it is a science.

I am sure all of us will agree that we did not look forward anxiously and gleefully for this year to arrive. It came too quickly. It was on us before we realized it. Looking forward, 50 years is a long time; but, looking backwards, it is just the day before yesterday.

Some of these doctors are still in the active practice of medicine and they are probably as happy or happier than the rest of us. But those of us who have retired and have hobbies and pursue those hobbies find retirement a very enjoyable way of life. Personally, I can say that I enjoyed the practice of medicine very much and now I'm enjoying retirement equally as well. One thing sure, I can go to bed at night knowing that I'll not be aroused to make a hospital or house call. I don't think that any doctor ever became accustomed to making night calls.

Now speaking of night calls reminds me of a doctor who called a plumber in the middle of the night to come and repair his toilet. The plumber came promptly, the trouble was minor, and he repaired it in a few minutes. The doctor asked how much and the plumber said $75. "What! $75?" Said the doctor, "Well, I've made many night calls and never did charge such a fee." And the plumber said, "Neither did I when I was a doctor."

Now, Dr. Steen, on behalf of this year's Fifty Year Club I would like to thank the Indiana State Medical Association for honoring us today, and also for the beautiful Fifty-Year pin and the framed certificate of distinction which was mailed to us. I assure you we appreciate it very much.

ACS Issues Statement

It is highly unusual for the Regents of the American College of Surgeons to issue public statements on medical problems. In view of the increasingly serious situation regarding professional liability insurance, I have been asked by the Regents to give the widest possible circulation to the following statement.

C. Rollins Hanlon, M.D., F.A.C.S.
Director

THE Regents of the American College of Surgeons feel obligated to inform the public that the rising number of lawsuits against physicians is seriously threatening the quality of surgical care and increasing its cost to patients.

Some surgeons feel compelled to treat patients under a concept which stresses avoidance of litigation rather than the application of their best clinical judgment.

Instead of attempting procedures which may cure the patient, but have a higher risk of failure and exposure to the threat of a lawsuit, some surgeons may prefer to use standard, proved, conservative methods which might bring relief to the patient, but will not cure him.

The rash of lawsuits has driven many other surgeons to still another extreme. To protect themselves against possible litigation, they are being forced to order costly tests and elaborate x-rays which under normal conditions would not be required.

It is not generally appreciated by the public that hazards are inherent even in well established surgical procedures. The practice of medicine is a combination of art and science. Even though medicine as a science is highly advanced, a precise result in treatment never can be guaranteed. Although the physician may demonstrate the highest possible knowledge and skill so that a jury would not be expected to find fault with his actions, it still might find against the doctor, simply because the doctor has insurance and the patient had a bad result.

To protect himself against unexpected litigation, a surgeon, like an automobile driver, must have adequate liability insurance. Because insurance companies are being required to pay out larger and larger compensation, they are finding it necessary to raise their premiums for doctors. Several insurance companies have ceased to issue professional liability insurance. In Hawaii, as well as in certain southwestern and western states, many surgeons are faced with non-renewal of their policies even though they never have been involved in any medico-legal action. This may force some surgeons to give up their practice, thereby aggravating the problem of an already deficient supply of physicians.

The Regents of the American College of Surgeons believe the problem extends beyond the profession and requires increased public awareness for its solution.

Editorial Notes . . .

The FDA, as a result of the University Group Diabetes Program study, has recommended further studies, and pending results of such studies, recommends that the use of Orinase (tolbutamide) and other sulfonylurea type agents, Dymelor (acetohexamide), Diabinese (chlorpropamide), and Tolinase (tolazomide), should be limited to those patients with symptomatic adult onset nonketotic diabetes mellitus which cannot be adequately controlled by diet or weight loss alone and in whom the addition of insulin is impractical or unacceptable. The oral hypoglycemic agents are not recommended in the treatment of chemical or latent diabetes, in suspected diabetes, or in pre-diabetes, and are contraindicated in patients with keto-acidosis.

Transplant research at Harvard has shown that livers of monkeys may be removed, preserved for five hours by simple cooling, and then reimplanted in the same animals, with recovery and good health for 18 months at least. No oxygenators or pumps are necessary; storing in cooled salt solution is sufficient.

Persons who accumulate publicity by circulating pseudoscientific data in an attempt to defame a manufacured product or manufacturing process may have nuisance value but they are almost never exactly correct in their charges. A professor at the University of Pittsburgh recently stated that the normal operation of the nuclear power plant at Dresden, Ill., has been the cause of an increase in infant mortality downwind from the Dresden site. The Public Health Service says in part: "Exposure to population through consumption of food and water from radionuclides released at Dresden are not measurable. Radioactive gases from the Dresden stack are only a small fraction of natural background radiation." Infant mortality in Illinois rose in 1964, peaked in 1965, then lowered to a satisfactory level in 1969, all while the nuclear plant was in normal operation. Some of the adjacent counties experienced disproportionately high rates but these counties are not "downwind," but are almost the opposite.

Encouraging reports about the development of a vaccine to combat Pseudomonas infection in burned patients were received by the surgical section of the American Academy of Pediatrics recently. Louisiana State University and Parke-Davis are working jointly on the project. The vaccine can be given after the burn injury. If given before the sixth day significantly higher antibody levels are obtained. A vaccine-treated child who had contracted Pseudomonas infection survived, an unusually happy result. The studies are continuing.

An intraocular balloon for the treatment of massive retinal detachment and tears has been made by Firestone. The uninflated tip is 1.5 millimeters in diameter and inflates to 10 millimeters. The stalk contains two tubes, one to inflate and deflate the balloon, the other to inject air or saline into the eye to fill the space as the balloon is deflated. The balloon will gently replace the retina and maintain it against the choroid until spot welding can be performed.

High school students in New Jersey are given an opportunity to work and learn in hospitals during the summer by virtue of a program which is financed by Ciba, Merck and Schering. The grant of $41,000 is given to a research arm of the New Jersey Hospital Association and used to provide six to eight weeks of hospital work for more than 70 students. The program is called SHOP—Student Health Opportunities Program. This year is its third.

Public hospitals have been furnishing about 20% of the total health care. There are more than 300 public, non-federal, hospitals in the U.S. Most of them are in trouble. Financing, staffing, and equipment and repair deficiencies are rampant. Attempts to provide private-type care for everyone will make step-children of public hospitals unless the problem is handled correctly. The American Hospital Association has published a special issue of HOSPITALS which outlines the difficulties. Moves away from government control are advocated. Affiliation with medical schools or administration by independent corporations are beneficial. No matter how the shortages are corrected the hospitals must be preserved as functioning units—the deficit in health care, otherwise, would be staggering.

The Federal Trade Commission will probably have a regulation which will require a cautionary statement about advertising of cyclamate-containing artificial sweeteners as nonprescription drugs. The statement suggested is that such a sweetener may be dangerous to health when taken in large doses, that it should only be used with calorie-controlled diets by diabetics or obese patients under medical supervision, and that medical supervision is essential for safe use.

The Commonwealth Fund has awarded a grant of $285,000 to Alderson-Broaddus College, Philippi, W.Va., to assist in the development of a college-degree program for the training of physicians' assistants. A 1968 grant launched the special curriculum which this year enrolled 40 freshmen and sophomores. The new grant will be concerned with designing clinical clerkships for the junior and senior years.

Inept publicity work by the FDA on the controversial clinical report on Orinase has resulted in bad public information. Upjohn Laboratories, the makers of the drug, deplore the method of releasing the information. Upjohn also disagrees with the interpretation placed on the Orinase study. It will be quite some time before the real truth is determined, but it is interesting to note that, so far, the only reaction produced by the U.S. study on the British Committee on Drug Safety and the Canadian Food and Drug Directorate, both of which are fairly reliable on clinical matters, has been, at most, a quiet yawn.

Glaucoma screening was conducted at a recent U.S. Conference of Mayors. Ophthalmologists examined 169 mayors and their aides and found five "suspicious" cases. These were referred for complete eye examination by their own ophthalmologists. The National Society for the Prevention of Blindness has found that some 2% of persons 35 years and older screened for glaucoma will be found positive upon referral and subsequent eye examination. The AMA convention screening procedures have discovered about the same findings among doctors.

Recent survey by the American Academy of General Practice shows that family doctors have increased their income since Medicare and Medicaid started, but have also increased the number of patients seen and the hours worked. Net earnings were found to be up by only 5% or less. This confirms the contention that doctors are caring for the same patients in the main that they cared for previously and did so free of charge. The Medicare and Medicaid payments became net profit because the practice costs were practically the same in both instances.

Dr. Marcus M. Jensen, microbiologist of Brigham Young University, has devised a stainless steel device to collect sputum samples by aerosol induction. Protection is afforded to hospital personnel and to subsequent patients by the fact that the exhalations are collected by a filter. The entire assemblage can be sterilized for each patient. Tests have shown that all airborne microorganisms produced by the aerosol-induced coughing are immobilized.

Over half the babies born in the United States are to mothers under 25 years of age. The median age at which women have their first child has declined by 1.5 years since 1950. The median age for all mothers is 24.4 years. This is due partly to the tendency to bear children earlier and to the smaller size of families. The Metropolitan Life Statistical Bulletin cites the advantages of childbearing at a young age—the hazards of maternity are minimal in young women and both parents will be more likely to live through their child's period of dependency. Women past the age of 35 now contribute only 8% of all births.

The Department of Defense announces that no Armed Forces medical facility may refuse to perform requested surgical sterilization procedures as a matter of local policy, and that military hospitals are not required to follow state laws on voluntary sterilization. "Surgical sterilization procedures may be performed on eligible beneficiaries in military facilities in accordance with sound medical practice and subject to the availability of space and facilities and the capabilities of the medical staff."

Hospital expense per patient day in United States community hospitals is reported as $70.03 for 1969, up from $61.38 in 1968. Payroll expense was the major factor. Wages and salaries were up by 16.2%, patient-day cost up by 17.3%. The number of employees per patient has risen slightly: 280 per 100 in 1969, 272 per 100 in 1968.

Gus Schreiber, M.D., of Dallas, has developed a technic for telephone-transmission of electrocardiograms in compressed form so that the telephone transmission time is only one-sixth the time required by other methods. Dr. Schreiber also has a code system for transmitting the history and clinical data which will be of value to the ECG consultant.

A miniature pig has been developed for heart and circulatory research work. The National Society for Medical Research reports that the animal, developed especially for laboratory use, has a heart and circulatory system very similar to man's and, when subjected to diets high in cholesterol, will develop atherosclerosis. The "minipigs" have coronary heart disease and coronary attacks which resemble the same conditions in man.

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Occupational Medicine*

CHARLES H. RUSHMORE, M.D.
Indianapolis

OCCUPATIONAL medicine is now a recognized sub-specialty under preventive medicine and public health. It involves two years of classroom work in a postgraduate program, followed by a year of internship in an approved plant situation. The classroom work involves such things as data, statistics and how to use them, environmental control and measurements, and a great deal of psychiatry in the area of motivation and handling the work group.

Occupational medicine is:

1. The maintenance, restoration, and improvement of the health of the worker through the application of the principles of preventive medicine, emergency medical care, rehabilitation and environmental medicine.
2. The promotion of a productive and fulfilling interaction of the worker with his work through the application of the principles of human behavior.
3. The active appreciation of the social, economic, and administrative needs and responsibilities of both the worker and the work community.

The Edwin Smith Surgical Papyrus, reported to be the oldest medical literature (somewhere around 3,000 B.C.), describes surgical cases of patients who may have sustained injuries in the building of the Egyptian pyramids, for example—"Instructions concerning a gaping wound in the head, penetrating to the bone, smashing the skull, and rendering open the brain of the skull."

Hippocrates (460 - 359 B.C.) reported the sciatica of horseback riders. He gave us some euphemisms such as, "when in a state of hunger, one ought not to undertake labor." And "Those who are accustomed to habitual labors, although they be weak or old, bear them better than strong and young persons who have not become so accustomed."

Galen (130 - 200 A.D.) reported that students and scholars often suffer pains in the chest and dizziness from tallow candle fumes. He visited a copper mine in Cyprus and observed that "the workmen who carried vitriolic liquid ran with all speed from the mine to avoid death in the midst of their labors."

Paracelsus (1493 - 1541 A.D.) gave a masterful description of the symptoms of arsenic poisoning. "This disease may not be treated lightly. Phthisis, cough, stitch in the side, difficult breathing, vomiting, great thirst, dropsy with much swelling around the stomach, hard dry stools, and trembling — there are rashes on all of the limbs."

Ramizini (1633 - 1714 A.D.), a famous Italian physician who is considered to be the father of modern industrial medicine, wrote the first comprehensive textbook on occupational diseases. He noted that miners were more liable to experience difficult breathing, apoplexy and swelling of the feet.

In the 19th century, Thockrah described diseases peculiar to tailors, lead workers and others. On coachmen, he wrote "gentlemen's coachmen often suffer from the excess of nourishment. They eat more than they work. Having often to wait for their masters, they fill up their time by filling up the stomach. They also take ale too frequently."

Effects of Sickness

If an individual suddenly changes from the state of good health into a state of illness, the following may occur:

1. Cessation from work or daily routine whether intermittent or continuous;
2. Securing or acquiring emergency and/or continuing medical care;
3. Temporary disruption of family life patterns;
4. Family exposure to possible contagion;
5. A need for disability income;
6. Adjustment to a new daily routine in life resulting from: residual disability, asthenia, impaired function and adjustment to alternative work.

Many physicians lose sight of number 3, number 5 and number 6.

In order to prevent the abuse of various benefit or sickness and accident insurance plans to cover item number 5, industrial physicians

* Presented at a meeting of the Cass County Medical Society on March 2, 1970.

may ask for certain reports. Some attending physicians may overlook the fact that the individual will make a more rapid recovery if a portion of his overall concern can be removed, such as for his family income or his future regarding permanent disability or impairment.

The industrial situation is ideal for adult health supervision or the implementation of preventive health measures because it is a situation where large numbers of adults are concentrated, much as schools represent focal points for preventive medical efforts in children. We anticipate that preventive medical efforts in children will be transmitted to the family. It is more certain, however, that health awareness created in an adult will be taken home and other members of the family will be inoculated.

With the legislative trend towards socialization, exemplified by retirement payments, company paid insurance, hospitalization, and so forth, it appears to me that industry's role in adult health supervision can only grow.

Objectives of Preventive Medicine

The most plausible answer to the shortage of professional medical personnel lies in the practice of preventive medicine. The term "preventive medicine" no longer is restricted to the prevention of specific diseases but is, instead, an effort to create a concept of health consciousness which will result in better health. This "health consciousness" could help realize the goals of preventing occurrence or progression of disease.

The purposes of an employee health program are

1. To promote health and prevent illness;
2. To control or eliminate occupational health and safety hazards;
3. To reduce illness absence and employee turnover;
4. To lower the frequency rate and severity of accidents;
5. To lower the insurance costs, including workman's compensation, disability and medical care plans; and
6. To provide research and statistical data on occupational health and safety.

An occupational medical program is a program of preventive medical care provided by management to deal constructively with the health of employees as it relates to their work. The general functions of a medical program are:

1. Maintaining a safe and healthful work environment;
2. Supervising the employee's health through medical examination and proper job placement;
3. Providing medical care for occupational illness and injuries;
4. Providing limited medical care for non-occupational illness and injuries, with referral to the employee's physician for further care;
5. Counseling on health matters;
6. Promoting health education;
7. Offering consultation services to other employee programs in the company;
8. Cooperating with private physicians and community health organizations; and
9. Maintaining records and reports to meet legal and company requirements and to assure continuity of service to employees.

From another point of view, the overall functions of a medical program can be divided into several specific areas which can be examined in more detail.

1. Medical examinations. There are several types of medical examinations:

a. Pre-placement—the pre-placement medical examination is a health evaluation or health appraisal to assist the personnel department to place the candidate for work in a job for which he is, physically and emotionally fit. The examination should include not only a personal and family medical history but also a carefully documented occupational history indicating all jobs held, their dates and places, and the kind of work exposure sustained by the applicant. If any occupational disease has been experienced, the circumstances should be described in detail. The assessment of physical status should be carried further than the usual organ inventory, with notations of major or minor physical changes, for it should include an evaluation of functional capacity. At the time of pre-placement evaluation, immunization should be accomplished in accordance with company policy, site of work, or local work hazard. Personal protective devices should also be given to the job applicant at the time of pre-placement evaluation.

b. Periodic—health maintenance.

c. Occupational examination. Part of the control of the work environment is special clinical surveillance of the worker exposed to hazardous materials or radiation. At specific intervals, complete or partial physical examination should be conducted, with emphasis being given the organ system or the site most vulnerable to the chemical or physical insult.

d. Fitness examination.

2. On-the-job care:

a. Occupational illness.

b. Occupational injuries.

c. Non-occupational illness and injuries.

The care of chronic illness or protracted acute or subacute conditions unrelated to work is neither the func-

tion nor the responsibility of the medical department in industry. As customarily practiced, emergency or short-term care will be given an employee who presents a condition, either discomforting or threatening to life. The recognized objective in this form of care is completion of the work shift, and medication or rest facilities may be provided to permit this. The employee should be instructed to consult his private physician, and if he has none, he should be given the names of several so that a selection may be made.

For minor disorders, first aid or palliative treatment may be given if the condition is one for which the employee would not reasonably be expected to seek the attention of his personal physician, or to enable the employee to complete his current work shift before consulting his personal physician. To provide single-visit treatment for headaches, diarrhea, dysmenorrhea, or mild upper respiratory infection is saving both to the employee and employer. The saving of work time is effected further by the parenteral administration of various preparations on request of the employee's physician. Much of the misunderstanding regarding occupational medicine had its genesis in this function of the treatment of non-occupational illnesses and injuries.

3. **Supervision of illness absence:**
   a. Determination of adequate medical care and cooperation.
   b. Reviewing diagnoses.
   c. Making estimates of the length of disability for working planning purposes.
4. **Counseling:**
   a. To the employee in personal health matters. The members of the medical department are ideally located, philosophically and physically, to counsel workers in matters of health maintenance.
   b. To the company with regard to placement considerations, environmental control, management training: (A). Medical aspects of people at work and (B). Orientation to medical services, advice on attendance, medical-legal advice, advice on special health programs.
5. **Health education.**
   a. One-to-one basis;
   b. Group discussions in classes;
   c. Booklets;
   d. Displays and posters;
   e. Films;
   f. Articles on health and safety subjects in employee publications.
6. **Participation in other programs within the company.**
   a. Industrial hygiene. Industrial hygiene is the science devoted to identification, evaluation and control of environmental factors or stresses arising in or from the work place which impair the health and well-being of receptors within the industrial environment. In placing prime emphasis on the protection of the health of the worker, one cannot neglect the community environment nor the requirements for the safe usage of industrial products by the consumer. It is an interdiscipline relying upon the basic principles and tools of biology, chemistry, engineering, physics and others for the characterization and control of a safe industrial environment. The term "safe" is used to imply the absence or control of factors, materials, processes and equipment which in their operation, dissemination, or interaction could prove deleterious to the health or integrity of the worker. The maintenance of these controls is the responsibility of the medical department along with the safety department. When complete environmental control is not possible through the addition of precautionary caging, railing, automatic devices which render equipment inoperable, or special structures which allow work to be conducted safely at great heights, over deep open areas, or on fast-moving vehicles, then personal protective devices are provided the employee. Examples of these are leg protectors, fire-retardant suits, face shields, impact-resistant hats, etc. There needs to be control of dangerous materials which, through inhalation, ingestion, skin absorbtion, or entries through a break in the continuity of skin, could be taken into the body.
   b. Safety, on and off job.
   c. Food service.
   d. Plant sanitation.
   e. Insurance benefits and compensation.
7. **Community professional relationships.**
   a. Activities in professional societies.
   b. Activities in community programs such as tuberculosis, cancer, etc.
   c. Liaison with attending physicians, including promotion of the company image via medical media; information on results of employee health examination; promotion of the preventive approach to disease; research—study of employee sickness patterns; co-operation with academic groups, voluntary and public health agencies on health problems of mutual concern; referral of cases for private care, and cooperation with private physicians on employee rehabilitation at work.

It is easy to understand why many well-planned industrial health programs must concern themselves with

the environment in which the worker performs his job. Industry provides and controls that environment and, therefore, bears a moral and legal responsibilty for its effect on the worker. It may be somewhat more difficult, however, to see why industry should concern itself with the environment in which the worker lives for the 16 hours of non-working time each day.

Experience has shown that there are wide areas of inter-dependence and interaction between the living and working environment. There is a basic and essential unity that makes it increasingly important that occupational health activity be more closely associated and coordinated with other environmental activities.

The healthfulness of the in-plant environment must necessarily be affected by conditions in the community surrounding the plant. An inadequate or poor water supply may dictate the installation of private wells, pumps, and purifiers within the plant in order to insure adequate supplies of pure water. The community's control or lack of control over infectious diseases will obviously effect the plant's sickness and absentee rates. Community control or lack of controls of air and stream pollution will likewise affect the in-plant health effort in multiple ways. The adequacy or inadequacy of the community's supply of nurses and medical facilities will exercise a large influence upon the personnel needs and the scope of an in-plant medical program. Items such as hospital and ambulance facilities in the community will be reflected in the industrial medical department planning.

On the other side of the slate, the industrial plant already in existence affects the environment of the community of which it is a part. The plant's raw materials and finished products enter and leave by way of community transportation facilities, and manufacturing processes may create air and water pollution.

Diseases ranging from colds to tuberculosis may be transmitted from worker to worker and then carried outside the working environment to endanger not only the worker's family but the entire community. Industrial contaminants may be carried out of the plant on workers' clothing. For example, workers who have been exposed to nitroglycerine have been known to carry it home on their clothing, causing severe headaches in their families. Other examples are beryllium and fluorides.

8. **Records and reports,** both individual and administrative.
9. **Administration of the program,** which encompasses professional personnel, written policies and procedures, space and layout, equipment.

Summary

It is hoped that what has been presented has helped show what is being done in occupational medicine today and, more importantly, why.

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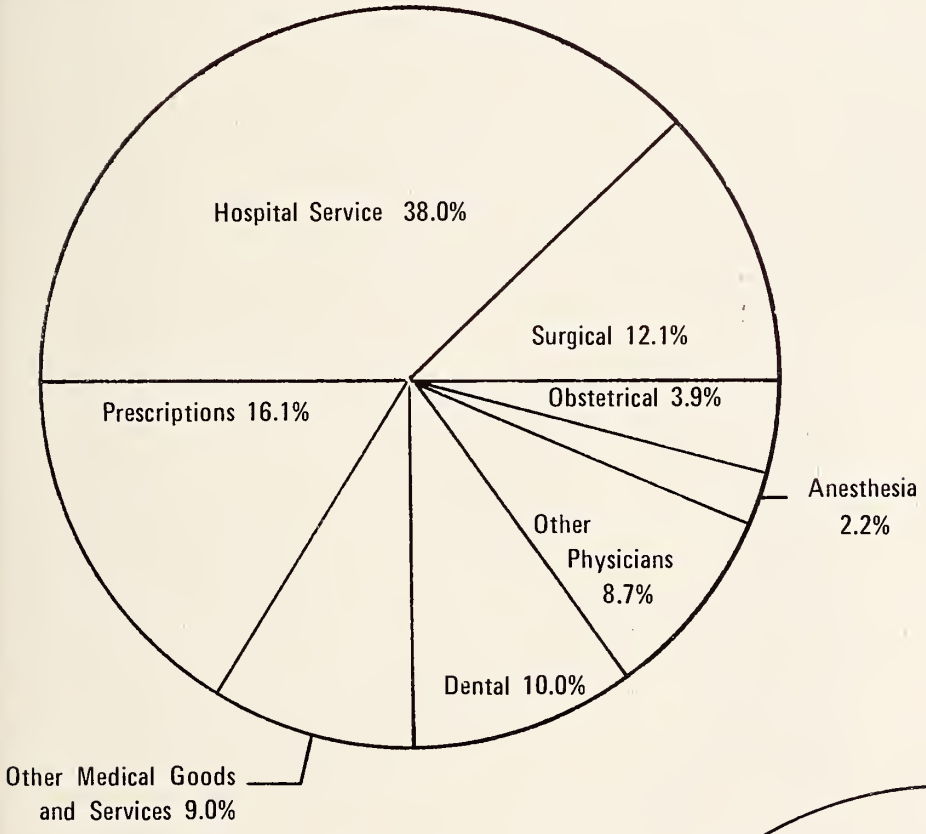
The Indiana Medical Foundation was organized to furnish support for the educational activities of the Indiana State Medical Association. These activities include programs for continuing education and the scientific publications of *The Journal.* Contributions made to the foundation are deductible by donors in accordance with the Internal Revenue Code. Bequests, legacies and gifts are deductible for federal estate and gift tax purposes. Memorial contributions made to the foundation will be formally recorded and acknowledgment will be sent to the family. Gifts, bequests, and memorial contributions may be mailed to the foundation at 3935 N. Meridian St., Indianapolis 46208.

Charting the Indiana Health Care Dollar

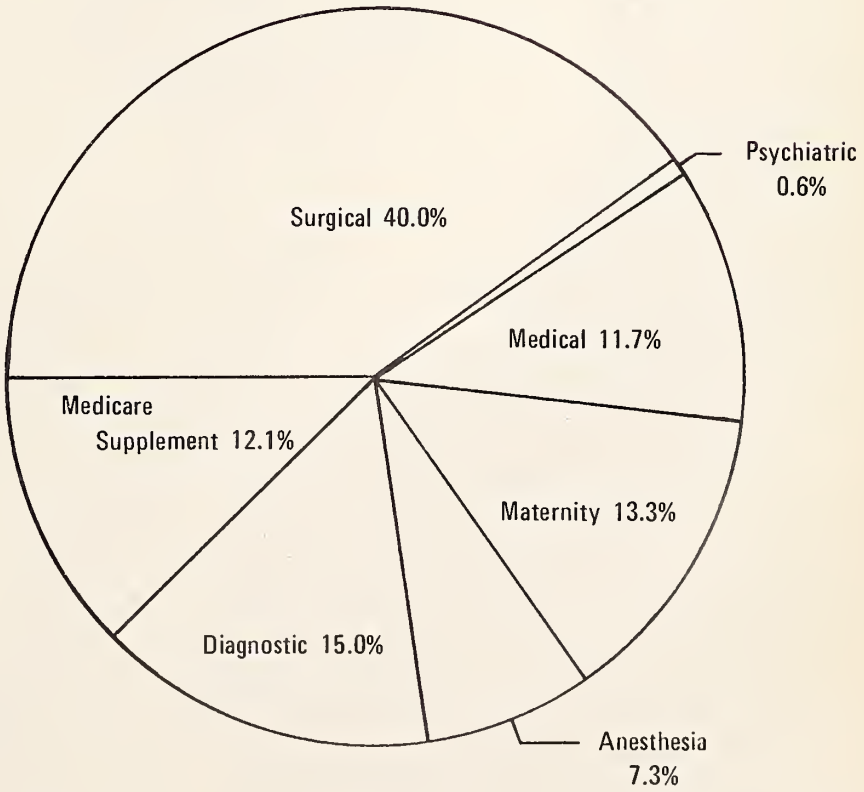
(One of a series prepared by Indiana Blue Shield)

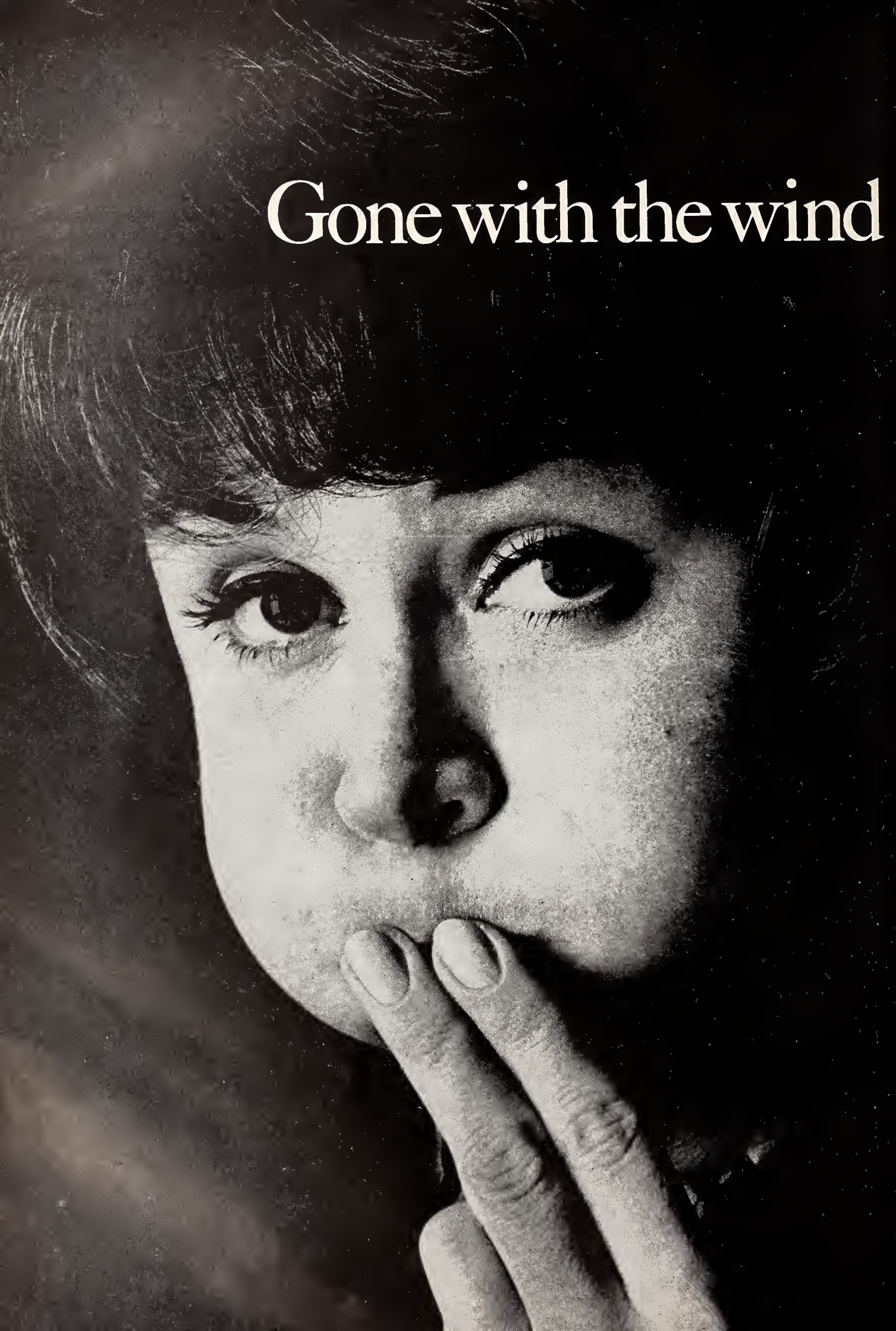
The charts below represent the estimated distribution of the 1969 Indiana health care bill, and the percentage distribution of the 1969 Blue Shield dollar. We thought these charts might be of interest to Indiana physicians.

Indiana's 1969 Health Care Bill
(Estimated)



1969 Blue Shield Dollar




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*Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

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Lounge Talk

LLOYD L. HILL, M.D.
Peru

POLITICIANS have interposed themselves into almost every facet of life. One finds it nearly impossible to offer an opinion on any subject without having to contend with political involvement. Indeed this is the essence of conservative lament today. I would be most gratified if politicians would disentangle themselves from my personal life. Instead they persist in becoming more and more ensnarled in all our activities. Their presence alone creates problems which superficially seem to justify their existence. They then contrive innovative panaceas which so thoroughly muddy the waters that an entire new regiment of civil servants must be added to the already vast army of leeches on our federal treasury to administer still another impossible program.

Whether Dr. Keplinger's assessment of "Lounge Talk" proves correct will have to stand the test of time and is truly irrelevant to the real issues. Even conceding the worthiness (which I do not) of his ends, Dr. Keplinger apparently lives according to the liberal dictum of ends justifying means.

"Lounge Talk" has attempted to address itself to issues indigenous to organized medicine. Its application to the political scene in general is a peripheral one touching upon such matters as they are contended with by the core of organized medicine. The official policies of organized medicine have been flagrantly violated on several occasions leaving the individual physician quite vulnerable to the merciless planners hellbent on dominating the universe. True enough, the "flagrant violations" have been externally motivated; but once perpetrated they have at least received the tacit approval of and, in some instances, the active cooperation of our leadership. Herein lies the purpose of "Lounge Talk."

Dr. Keplinger may be entirely right in his approach to social affairs. The future is an unknown quantity and quality on which he and I, at best, can only speculate. I would suggest, however, that if he is so impressed with his "democratic" approach to society by organized medicine, he at least come forth with majority concurrence on the floor of the House of Delegates of either the AMA or ISMA.

I am highly resentful of the fact that even though delegates of his persuasion have been a decided minority, somehow the policies of organized medicine are being perverted from conservative origins to ones acceptable to the liberal establishment. Is this what Dr. Keplinger means by "physical discovery and invention" in dealing with important problems of social affairs? Has liberal doctrine "invented and discovered" that it can get by flaunting any law or rule of fair play in order to achieve what it considers to be a justifiable end?

The experiences of today have their counterparts in history. Scientific progress is made by an orderly and cautious trial of the unknown adhering tenaciously to the tried and proven before proceeding to the promises of the new. Indeed, Jim, it is my contention that you, not I, experiment with our lives via the "willy-nilly circumstance of accident." For you, it seems, there is no history of mankind and, indeed, that our present social dilemmas descended upon civilization totally isolated from all prior knowledge! Without equivocation, I affirm the judgment that I seek answers to questions from dogmas and doctrines of the past in order to improve upon the latter. It is precisely through such methodology that I seek to avoid the sucidal results of liberal experimentation with alien schemes designed to abdicate our individuality for the sake of the "common good." By whose judgment? For what price is our Senator or Congressman for sale?

It was not the intent of this writer to create animosity within the organization. I had hoped that through such a means of communication, new interest in organized medicine could be aroused. After one year of writing, I am uncertain whether I have accomplished my purpose. Truly, I welcome the comment and opinion which rebuts my admittedly hypercritical and, at times, caustic style. Believe me, my purpose is to place emphasis, not disrespect. My arrogance permits me to believe still, like Barry Goldwater, that in the hearts of the majority of grass roots physicians, "they know I'm right!" Perhaps this is only a delusion—I've been given many diagnoses gratuitously by liberal, self-proclaimed "psychiatrists." No one should dare to question my sincerity, however, in staunchly supporting the ideals of the private practice of medicine. It is my appraisal that, without the support of the traditional organization, there is no hope for its survival. Unless the busy private practicioner is competently and conscientiously represented; the 30 hour-a-week salaried physician will be paid a fabulous sum while he expends his unlimited time influencing the policies of organized medicine.

Preparing "Lounge Talk" has been an enjoyable avocation. It does require a tremendous expenditure of precious time and energy. I shall be happy to continue but only if it performs a worthwhile service to the organization. Until I am satisfied that "Lounge Talk" will strengthen ISMA and organized medicine, I shall concentrate more of my time and energy toward more obvious worthy goals—my practice and my family.

I do sincerely hope that the vociferous class of 1953 will be proud of its personable representative, Dr. Peter Petrich, who was unanimously

elected President-elect at the recent ISMA Convention. The subtleties and paucity of sensitive issues involved at the 121st annual convention permitted a more leisurely deliberation which produced little of monumental political importance as it concerns the practicing physician. For those of you who are interested, I refer you to the official publication of proceedings of the House of Delegates elsewhere in the *Journal.* Indiana medicine is, indeed, fortunate in having Dr. Frank Ramsey as Editor-in-chief of our *Journal.* He and his staff have contributed countless hours compiling a publication which presents a comprehensive, honest, forthright and erudite display of medical information. It was my hope that "Lounge Talk" would compliment the excellent literary taste of the *Journal.* Dr. Ramsey has been a most tolerant gentleman!

The late General Douglas MacArthur held my highest respect and he was one I would be most pleased to emulate; but, at the moment, I'm uncertain at which point in history. Was it at Corregidor when he said, "I shall return" or was it in the halls of Congress when he said he'd "just fade away"? History records this great statesman and soldier stood true to his word unto death. The world was a better place because of this man. The utopian ideals of our enthusiastic youth are far more likely to be found in the realities exemplified by General MacArthur than they are in the hypocracies of expedient politicians. The choice and its consequences rest entirely upon our youth. May God grant them the wisdom and serenity of this great "old soldier"! ◄

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ABSTRACTS, BOOK REVIEWS

ANAPHYLACTOID EDEMA

Hans Selye, Green, Inc., St. Louis, Mo., 1968, $26.50, p. 318; 36 figures and innumerable tables; glossary and a colossal compendium of references.

Prof. Hans Selye is world famous for much very original research: I am looking on my shelf that is graced by such volumes as "Chemical Prevention of Cardiac Necrosis" and "Calciphylaxis" and "The Mast Cells," etc. I've heard his lucid lectures many times. I've been in distinguished gatherings where there has been speculation as to the why of Dr. Selye never having received a Nobel prize.

"Anaphylactoid Edema" certainly carries on the tremendous quest for knowledge that has always been his hallmark. At the very start, the reader is regaled with a *glossary* that permits the use of code letters for frequently repeated items. Also, the author states that he will write in *large* type the essence of his thinking and in *fine* type the speculative commentaries and the huge reel of references. Do take the hint. You and I read the large type; leave the fine print to the super-expert.

The body of the work may be repetitious but is still well worth re-reading. I became engrossed in the clear crisp statements on this still-expanding frontier of medicine. Dr. Selye does dote on the obscure wording and the coining of new words. Thus, on p. 16, he says, ". . . standard procedure for the *obtention* of an AE-L." "Obtention" is in no dictionary; he really means "standard procedure to *obtain* an AE-L." Again, on p. 245, he speaks of "ordinary phlogogens." We no longer speak of "phlogiston," but then, English is not Prof. Selye's native tongue, in spite of his extraordinary fluency in same.

All nit picking aside, this is a truly splendid monograph. I enjoyed it thoroughly. The paper, binding and general format are truly superb. The M.D. perusing it will have a real treat. The true gourmet will be returning for the overlooked tidbit here, there, everywhere!

ARNOLD LIEBERMAN, M.D.
New York

PRIMER OF IMMUNOELECTROPHORESIS

P. C. Arguembourg et al., Ann Arbor-Humphrey Publishers, Ann Arbor, Mich, $8.25, p. 83; 117 illustrations and 1 table, 1970.

This thin but beautifully put together volume is precisely what its title says, a primer. In the simplest possible language, with precisely oriented illustrations on the HOW plus beautiful offset prints of the results, the reader is hand-led on the path to knowledge.

For the medical student, for paramedical technicians—even for the less than knowing M.D.—this is the volume to get and use. Congratulations to the authors and the publishers!

ARNOLD LIEBERMAN, M.D.
New York

HANDBOOK OF CHEMISTRY AND PHYSICS 50TH EDITION

Chemical Rubber Co., 1970. Chief Editor: Robert C. Weast, Ph.D.; almost 50 collaborators. Sections A through F. 8" x 11" x 3"; 5½ lbs. weight.

Comparisons (they say) are odious. I am looking at the *eighth* edition (1918) of this handbook; I had acquired it as almost my very first purchase upon entering the University of Chicago as a very young teen-ager. This *50th* edition is some *TEN* times larger: Its contents? Well! The tables of logarithms (both to the natural and base 10), the English-metric conversions, relative humidity—a few other unchanging constants are still as before. What else? Well! The whole panorama of the passing scene is mirrored in the additions, emendations and deletions. Einstein is no longer derided; he is the parent of the Atomic Age. The electron has been weighed; the electron miscroscope is with us; the laser beam does its work; we have the radio and TV; the computers are in their third generation: and so on and so forth.

As usual, the binding and format are superb; spot checking, I could find no errors. One can only congratulate the editors and publishers on their magnificent coordinated efforts. I do wonder how the handbook will appear in the edition coming due at the start of the next century—that is only 30 years away . . . .

ARNOLD LIEBERMAN, M.D.
New York

Abstracts From Various Literature, Prepared by AMA

PERFORATING WOUNDS OF HEART CAUSED BY CENTRAL VENOUS CATHETERS

C. T. Fitts et al. (80 Barre St., Charleston, S.C. 29401)
J. Trauma 10:764-769 (Sept.) 1970.

In a relatively short period of time four cases of perforation of the heart by indwelling central venous polyethylene catheters have occurred in one institution. All resulted in death, three due to pericardial tamponade. Warnings concerning intracardiac placement are conspicuously absent. It is worthy of note that the perforation apparently occurs slowly. Tamponade appeared from six hours to eight days following the placement of the catheter in these and the previously reported patients, and in each case the volumes of fluid which had been administered through the cannula made it evident that the perforation did not occur at the time of placement.

POTENTIATION OF WARFARIN-INDUCED HYPOPROTHROMBINEMIA BY CHLORAL HYDRATE

E. M. Sellers and J. Koch-Weser (Massachusetts General Hosp., Boston 02109)
New Eng. J. Med. 283:827-831 (Oct. 15) 1970.

During therapy with chloral hydrate, one of its major metabolites, trichloroacetic acid, accumulates in plasma to more than 80 mg/liter. Trichloracetic acid is highly protein-bound and displaces warfarin from binding sites on plasma albumin at 3C and 37C. The resulting increase in the concentration of free plasma warfarin leads to a 25% shortening of the biologic half-life of warfarin. During chronic warfarin therapy the trichloroacetic acid-induced increase in free plasma warfarin also potentiates the depression of vitamin K-sensitive clotting factor synthesis in the liver. Administration of 1 gm of chloral hydrate daily for one week increases the hypoprothrombinemic effect of warfarin by 40% to 80%. Chloral hydrate should be used with caution in patients receiving oral anticoagulants. To prevent excessive hypoprothrombinemia, a reduction in warfarin requirements should be anticipated when chloral hydrate therapy is begun.

SYSTEMIC CHEMOTHERAPY FOR ADVANCED BREAST CANCER

A. A. Fracchia et al. (Memorial Hosp. for Cancer and Allied Diseases, New York 10021)

Cancer 26:642-649 (Sept.) 1970.

During a 20-year period, 377 women with primary advanced or metastatic breast cancer were treated systemically by various chemotherapeutic agents and were considered suitable for a detailed analysis of therapeutic results. Fifty-five (15%) of these experienced objective remission of palpable or demonstrable disease for two months and 10% for six months, but 19.6% died within one month after the initiation of treatment. Two hundred seventy-one of the patients in this study had been previously treated by additive or ablative hormone therapy and at the time chemotherapy was given, a majority had multiple metastases. The poorest therapeutic results were obtained when the metastases were located in the bones, brain, or lungs with lymphangiectatic involvement, and in the liver with jaundice or abdominal ascites. When there were failures with subtoxic doses, better results were obtained by using a different cytotoxic agent rather than increasing the amount of the initial drug. Comparative results suggested that objective responses declined in the following order: methotrexate, Leukeran, thio-tepa, velban, 5-fluorouracil, cytoxan, and nitrogen mustard. When the chemotherapy was combined simultaneously with other palliative measures, the results in the chemotherapy group were improved, but infrequently exceeded the response rates of those following the use of additive or ablative hormone therapy alone. With few exceptions, chemotherapy should be used to supplement rather than to replace other measures.

LEVITATION IN TREATMENT OF LARGE-AREA BURNS

R. Sanders, J. T. Scales (Royal National Orthopedic Hosp., Stanmore, Middlesex, England) and I. F. K. Muir.

Lancet 2:677-680 (Oct. 3) 1970.

The treatment of seven patients with severe burns by levitation on a hoverbed, using humidified, warm, and sterile air is described. Burns of any extent, distribution, or thickness may be simultaneously and eompletely dried at a greater rate than by any other available method. Nursing is simplified and fewer nurses are required in the acute phase of treatment. Burn wounds did not become clinically infected until separation of the eschar and then healed quickly with excellent survival of the grafts. Follow-up showed scarring to be normal, pain was relieved, there was no vomiting, and sleep was normal. Free movement and careful positioning of the patient is possible without lifting and treatment of pressure areas is made unnecessary. Body temperature can be controlled. The burn is exposed to air but not to view. The levitation equipment has been proved safe, and noise is reduced to acceptable levels. The "microclimate" permits conditions which are ideal for patients and attendants.

CONTROL OF LYMPHOCYTE LEVEL IN BLOOD

P. C. Vincent (Kanematsu Memorial Institute, Sydney Hosp., Sydney, Australia and F. W. Gunz.

Lancet 2:342-353 (Aug. 15) 1970.

This hypothesis proposes that small lymphocytes carry a recognition site on their surface, that detection of lymphocytes carrying this recognition site (possibly during migration across the endothelium of the post-capillary venule) inhibits lymphocyte proliferation, thus maintaining normal numbers of lymphocytes, that the recognition site is identical with the phytohemagglutinin-responsive site and is closely associated with sites reacting with specific antigens, and that the recognition site is lost or blocked in chronic lymphocytic leukemia and in some of the lymphomas.



New Life Insurance Program Available

Your new Indiana State Medical Association's Life Insurance Program is a reality! A sufficient number of eligible members took advantage of this splendid plan so that the Valley Forge Life Insurance Company placed the program in effect on November 1, 1970.

Such spontaneous response points up the need many members have felt for life insurance protection at very attractive mass purchasing premium rates. In these inflationary days of rising costs of everything, many doctors, as others have, are finding that their life insurance programs have fallen behind their families' needs and liquidity required for estate tax and probate expenses at death. This program provides each eligible member a means to restore to his life insurance estate an amount that has been eroded away by inflation—and at premium rates not available on an individual basis, and the policies are convertible. This is a tangible example of one of the benefits derived from membership in ISMA!

As more members enroll in the plan certain questions are being received which indicate that some are considering use of the program for other than personal or family reasons. For this reason, we are listing below a few of the more obvious uses which may be made of this life insurance:

1. *Estate Liquidity*—To pay estate taxes, state inheritance taxes and administrative expenses. After consulting with your attorney and C.P.A. you may wish to designate someone other than yourself as the owner of the policy.
2. *Support of Dependent Relatives*—To provide money to support dependent or disabled relatives, such as a child or dependent father or mother.
3. *Assist in Education* of your child—by supplementing any amount now allocated in your present life insurance program for this purpose.
4. *Business Insurance*—With the formation of more and more professional corporations, this life insurance plan can be made a part of the funding of stock liquidation agreements calling for the sale and purchase of a deceased stockholder member's interest in the medical corporation.
5. *Charitable Gifts*—This program may be used as an excellent and inexpensive way to provide a gift to your favorite charitable institution upon death, *without reducing your present life insurance program!*

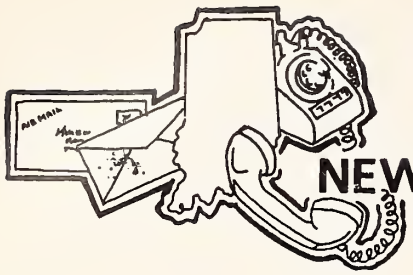
The above represent general areas where the ISMA Life Insurance Program may be used to good advantage by ISMA members. Each member should apply these general areas to his own individual situation and consult with his personal counselor on matters of law and taxes. ◄

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NEWS NOTES

74 Golfers Enjoy Tourney In Spite of Wet Weather

The 1970 golf tournament of ISMA was played at the South Bend Country Club on October 13, in perfect Scottish golf weather, rainy and misty as well as cool. Seventy-four members participated—the largest attendance ever.

Scoring was as follows:

	Merchandise Certificate
1. Low gross	
1st — B. J. Roberts, South Bend.	$15.00
2nd — Glen Hawkins, South Bend	10.00
Tom Johnson, Indianapolis	10.00
4th — Marshal Stine, Bremen	7.50
5th — Ernie Dietl, South Bend	5.00
2. Low net	
1st — Bob King, South Bend (1st place trophy)	$10.00
M. B. Gossard, Tipton (2nd place trophy)	10.00
James Rimel, Plymouth (3rd place trophy)	10.00
Phil Bowser, Goshen	10.00
5th — Wm J. McCraley, South Bend	7.00
6th — E. DeGrazia, Valparaiso	5.00
Howard Henry, Knox	5.00
Wm. Thompson, Winamac	5.00
3. Best-ball pairs (partners were drawn by the committee)	
Tied for 1st place were 3 teams:	
Al Dingley, South Bend Don Mason, Angola	1st place trophy 10.00 each
David Ross, Gary Phil Bowser, Goshen	10.00 each
Jim Wilson, South Bend Bill Luther, Elkhart	10.00 each
4. Best ball foursomes (best two net balls, each hole)	
1st — Glen Hawkins, South Bend B. J. Roberts, South Bend Edwin Walker, South Bend Al Dingley, South Bend	12.50 each
2nd — Al Donato, Indianapolis Tom Johnson, Indianapolis Ernie Dietl, South Bend Sam Bechtold, South Bend	12.50 each
3rd — Frank J. McGue, Michigan City John Phillips, Michigan City Bien Ticsay, Michigan City (4th man drawn from hat)	7.50 each
4th — Leon Chandler, Goshen Phil Bowser, Goshen Neil Harris, Goshen Robert Craig, Syracuse	7.50 each
5. Closest tee shot to pin on hole # 15	
Leon Chandler, Goshen	10.00

Following the tournament, there was a dutch treat cocktail hour, with the tournament committee providing a cheese hors d'oeuvre table.

Dinner was served at about 7:15 P.M., and was an excellent prime rib.

Prizes were distributed, and a W. C. Fields movie related to golf was shown.

The following workers and contributors deserve special thanks:

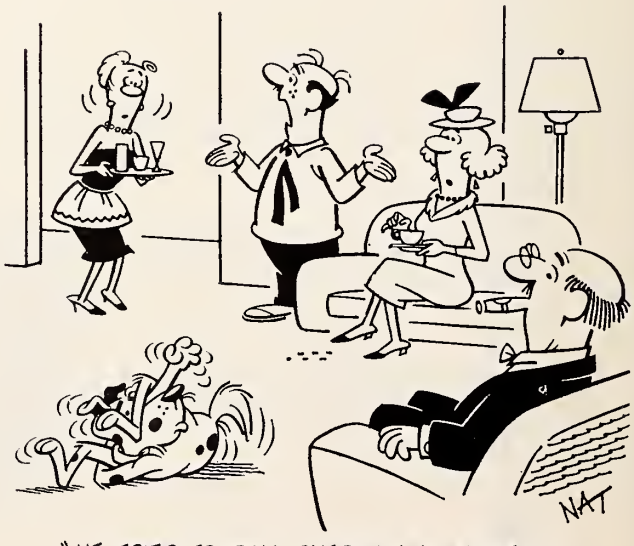
1. Pfizer Laboratories (Steve Schmidt, representative) contributed the trophies at a cost of $90.00
   Mr. Schmidt also located the W. C. Fields movie, and brought along a projector and showed the movie after dinner.
2. Wayne Pharmacal Co. (George Priebe, South Bend Manager) contributed $50.00 toward the cost of the golf hats given to all entrants.
3. Abbott Laboratories contributed 10 dozen Faultless golf balls, one to each entrant, rest given away after dinner to non-prize winners.
4. Stuart Pharmaceutical Co. (Terry Bolling, representative) contributed 80 packages of plastic tees which were distributed to all entrants.

AMA Moves to Cut Graduate Training

Steps in reducing the length of graduate medical education were taken when the AMA House of Delegates approved two recommendations of the Board of Trustees and the Council on Medical Education. The two recommendations aimed at "unification of the internship and residency years into a coordinated whole" state:

1. After July 1, 1971, a new internship program shall be approved only when the application contains convincing evidence that the internship and the related residency years will be organized and conducted as a unified and coordinated whole.

2. After July 1, 1975, no internship program will be approved which is not integrated with residency training to form a unified program of graduate medical education.



"HE TRIED TO ROLL OVER, SIT UP, SHAKE AND PLAY DEAD - ALL AT THE SAME TIME."

College Names New Members

The American College of Physicians announces the induction into membership or fellowship of the physicians in Indiana listed below.

Bedford:
Member: Guy H. Waldo, Jr., M.D.
Bluffton:
Member: Charles W. McCaslin, M.D.
Evansville:
Fellows: Marshall S. Miller, M.D.; William A. Vincent, M.D.
Member: Jerry D. Becker, M.D.
Fort Wayne:
Member: Don E. Miller, M.D.
Indianapolis:
Fellows: Henry R. Black, M.D.; Alfred F. Fasola, M.D.; John A. Galloway, M.D.; William K. Nasser, M.D.; Arthur L. Norins, M.D.; Dana L. Shires, Jr., M.D.; David M. Smith, M.D.; Morton E. Tavel, M.D.; John F. Williams, Jr., M.D.
Members: David R. Challoner, M.D.; Richard N. Dexter, M.D.; James T. Higgins, Jr., M.D.
New Castle:
Fellow: Cloyd L. Dye, M.D.
West Lafayette:
Member: Fred M. Kuipers, M.D.

Dr. Tavel Develops Heart Sound Recorder

The Tavel-Andries Stethosonus® Stethoscope, which was developed by **Dr. Morton E. Tavel, of Indianapolis,** and Francis Andries, President of Computer Medical Sciences Corporation, has been incorporated into a system which provides a Heart Sound Recorder. The resulting recording can be used as the input for a computer prepared phonocardiogram. Computer Medical Sciences will provide a computer analysis from a recording for a nominal fee.

New Board Members Chosen

Elections by the Board of Trustees have provided three new members of the Editorial Board of *The Journal*. Dr. W. D. Snively, Jr., of Evansville was elected to succeed himself and Dr. Elton Heaton of Madison was elected to the Board, each for a full three-year term. Dr. Steven Beering of Indianapolis was elected to fill the unexpired term of Dr. Jack Hickman, who resigned due to his acceptance of an assistant deanship with the University of Southern Florida School of Medicine at Tampa.

Dr. Loh Conducts African Medical Tour

An African Medical Tour was successfully sponsored and conducted by the Fort Wayne Medical Society for members of the Indiana State Medical Association September 7-20 under the chairmanship of Larry Pickering, Travel Committee, and **Dr. W. P. Loh,** Medical Seminar Committee. The tour was one of the 13 African Medical Tours involving 11 state medical societies. Dr. Loh served as medical program chairman for all 13 groups and traveled with the first group representing the Erie and Monroe County Medical Societies of the State of New York. Each group traveled by a chartered jet and spent four days each in Morocco, Kenya and Tunisia.

South Pacific and Mediterranean Medical Tours Scheduled

Dr. Wei-Ping Loh, Gary, has been working on medical programs for 1971 South Pacific Medical Tours which will be participated in by members from at least 10 state medical societies and have been scheduled for the months of February and March.

Each medical group will spend four days each in New Zealand, Australia and Tahiti for the two-week air trip. Dr. Loh is also arranging a medical program for a Mediterranean air/sea cruise which will be participated by a similar number of medical societies and has been scheduled for the months of August, September and October. It is also a two-week trip which involves air transportation to Nice, France, or Athens, Greece, and a Mediterranean sea cruise with brief stops at 12 beautiful seaports. Some of the medical meetings will be held on the luxury cruise liner.

Foreign medical institutions which have already agreed to participate in the medical programs mentioned above include University of Auckland, University of Sydney, University of New South Wales, local hospitals and the National University of Athens.

Dr. Loh has previously served as medical program chairman for Orient, South American and African tours involving medical societies in 20 states and was named as a medical ambassador.

Child Abuse Legislation Subject of New Book

The American Humane Association has published a book of 134 pages entitled "Child Abuse Legislation in the 1970's," which presents an analytical study of the current state laws for reporting child abuse. It outlines the changes in laws in the past five years, the current status, the novel approaches to the problem in new laws, the problem areas and the need for better services to protect children. It is written by Vincent De Francis, the Director of the Children's Division of the Association. Copies may be obtained at $1.50 each by writing the Association at P.O. Box 1266, Denver 80201.

Dr. Green Chairs Forum At White House Conference

Dr. Morris Green, Indianapolis, was the Chairman of one of the Forums of the White House Conference on Children. Several thousand delegates attended. They were grouped for discussion purposes into 26 different Forums. The Forums began preparing for the Conference many months in advance by collecting information. Dr. Green's Forum was concerned with "Keeping Children Healthy: Health Protection and Disease Prevention."



Dr. Loh is standing at left of photo.

Dr. Reed Honored

Dr. William C. Reed, formerly of Bloomington, who was a member of the ISMA Fifty Year Club this year, was honored by a special meeting of the Monroe County Medical Society recently. Dr. Reed now resides in Naples, Florida. He will be remembered by many friends for his professorship of anatomy at Bloomington during the many years in which he carried on a busy surgical practice.

Dr. Cohen Named Assistant Professor

Dr. Hyman L. Cohen, Gary, has been appointed an Assistant Professor of Neurology at the Stritch School of Medicine of Loyola University, Chicago.

Dr. Cohen was also recently elected a Fellow of the American Academy of Neurology. He has also received permission from Food and Drug Administration for investigation on the antiparkinson drug, L-DOPA.

Dr. Loh to Teach in Taiwan

Dr. WeiPing Loh, Gary, has accepted an invitation to teach for a short period in 1971 as a Visiting Professor of Clinical Pathology at the National Taiwan University College of Medicine in Taipei, Taiwan. The school is one of the few well-recognized medical schools in Southeast Asia.

Mayor Receives Award For Drug Control Efforts

Indianapolis Mayor Richard Lugar, was recently presented with a national award of distinction for advertising excellence, in recognition of his efforts to control drug traffic. The award was made in behalf of creativity '70 by James W. Sharp, president of Designersharp and Associates of Indianapolis, creators of the advertisement.

The advertisement pictures a wheat field with the headline, "Wheat grows straight and tall and healthy as nature intended. So should young men and women. Support Mayor Lugar's task force on drug abuse."

Public Affairs Pamphlet On "Troubled Child" Available

Parents concerned about their child's behavior may be guided by a new Public Affairs Pamphlet "Help For Your Troubled Child." The pamphlet discusses the kinds of behavior which may call for professional help, where to find such help, and what to expect from treatment. Authors are Alicerose Barman and Lisa Cohen of the North Shore Mental Health Association and Irene Josselyn Clinic, Northfield, Ill. Write for Public Affairs Pamphlet No. 454. Price 25 cents. Address: 381 Park Ave. South, New York City 10016.

From *The Journal* 50 Years Ago

Some distinguished leaders of surgical scholarship and practice advocate the use of other suture materials in this field. It has been stated that it is a violation of a surgical maxim to use a metallic suture in a tissue which is constantly in motion. I believe, however, that the use of silver wire in vesicovaginal fistula is rather to be considered as a contravention of a surgical dogma. Silver wire is always sterile. It surely cannot be contaminated in the sense that absorbable suture material may become contaminated.

The value of silver as a bactericide is well known. One has only to refer to the sovereign germicide, nitrate of silver and the various silver albumen compounds which are so efficient, as antigonorrheica.

Perhaps one of the most enthusiastic friends of silver as a bactericide is Rovsing of Copenhagen, who uses silverized catgut and also silverizes his gauze.

Assuming that silver wire does possess virtues which cannot be attributed to other suture materials, so far as this particular field is concerned, it becomes an interesting study to determine the reason for this difference. It is hardly scientific to make the bald statement that the wire is so meritorious without explaining the rationale of its superior effect. After a considerable study of this problem clinically and some laboratory experimentation we are still obliged to admit that our faith in silver wire is based principally on empiric observation . . . . J. R. Eastman, M.D., Indianapolis, "Silver Wire in Vesicovaginal Fistula," *JISMA*, December 1920.



Campbell's Soups... wide variety...for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help —for these four very good reasons:

Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Even patients on special diets will find soups they can enjoy among the more than 50 different varieties available.



Nourishment Campbell's Soups contain selected meats and sea foods, best garden vegetables—carefully processed to help retain their natural flavors and nutritive values.

Convenience Within 4 minutes a bowl of delicious soup is heated and ready to eat.

Economy Campbell's Soups are inexpensive—an important consideration to those whose budgets are limited.

Recommend Campbell's Soups . . . and, of course, enjoy them yourself. Remember, *there's a soup for almost every patient and diet . . . and for every meal.*

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diphenoxylate hydrochloride .....2.5 mg.
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PROMPT ANTIDIARRHEAL ACTION
Roentgenographic studies demonstrate that the motility-lowering activity of Lomotil is concentrated in the first three hours and continues for at least six hours.

Clinical investigators have found ample confirmation of these determinations. Lomotil has reduced diarrheal urgency in many patients within one hour.

OPTIMAL ANTIDIARRHEAL CONTROL
Numerous investigators have remarked on the high degree of effectiveness of Lomotil in a variety of diarrheal disorders. Lomotil has given good to excellent relief of symptoms in many patients who had failed to respond to other measures.

UNSURPASSED ANTIDIARRHEAL ACCEPTANCE
Patients prefer Lomotil for its convenience, its prompt control of diarrhea and its relief of cramping and urgency. Physicians specify Lomotil for its dependable action and its relative freedom from side effects when taken as directed.

Warnings: Lomotil should be used with caution in patients taking barbiturates and, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Signs of accidental overdosage may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise.

Overdosage: The medication should be kept out of reach of children since accidental overdosage may cause severe, even fatal, respiratory depression.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:
3-6 mo. .. ½ tsp.* t.i.d. (3 mg.)
6-12 mo. .. ½ tsp. q.i.d. (4 mg.)
1-2 yr. ... ½ tsp. 5 times daily (5 mg.)
2-5 yr. ... 1 tsp. t.i.d. (6 mg.)
5-8 yr. ... 1 tsp. q.i.d. (8 mg.)
8-12 yr. .. 1 tsp. 5 times daily (10 mg.)
Adults: ... 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.
*Based on 4 cc. per teaspoonful.

Use of Lomotil is not recommended in infants less than 3 months of age.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

953

G. D. SEARLE & CO. • P.O. Box 5110, Chicago, Illinois 60680 • Research in the Service of Medicine

in cardiac edema

Dyazide®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

SK&F

Smith Kline & French Laboratories

Continuing Education For Physicians

POSTGRADUATE COURSES IN INDIANA

Common Neurological Problems

December 16, 1970 — Indianapolis

This course outlines basic principles of management of the neurological patient. The morning session is devoted to common neurological symptoms and signs: headache, dizziness, paresthesias, gait disturbances, and mental symptoms. The afternoon session turns to management of dyslexia, epilepsy, parkinsonism, and cerebrovascular disease.

Depressive Equivalents in Adolescents

January 6, 1971 — Richmond

Combining lecture and clinical demonstration, this course covers certain unique problems presented by adolescent patients seen in general medical practice. Live and taped illustrations will review special interviewing techniques, the adolescent identity crisis, the maintenance of therapeutically effective relationships with the adolescent and his parents simultaneously, and the rehabilitation of adolescents with chronic disabilities.

Recent Advances in Clinical Pediatrics

January 6, 1971 — Indianapolis

This postgraduate course covers recent advances in Pediatrics, emphasizing the clinical application of new methods in prevention, diagnosis, and management.

Topics to be discussed include: prenatal detection of genetic abnormalities (Dr. Ray Antley); diagnosis and management of inborn errors of metabolism (Dr. Ira Brandt); clinical implications of current knowledge regarding infant development (Drs. Gail Landy and Morris Green); management of patients with gastrointestinal symptoms (Dr. Joseph Fitzgerald); advances in pediatric hematology and oncology (Dr. JoAnn Cornet and associates); advances in pediatric cardiology (Drs. Donald Girod and Roger Hurwitz); current trends in pediatric nephrology (Dr. Carl Trygstad); pediatric endocrinology (Dr. James Wright); infectious disease (Dr. Jack Lukemeyer) and pediatric neurology (Dr. A. L. Drew).

Psychiatric Problems in General Practice

January 13, 1971 — Muncie

This six-hour course is designed to help the family physician recognize and treat emotionally disturbed patients encountered in daily practice. Participants will discuss techniques of eliciting emotional factors operative in the life of the patient, as well as ways in which such information can be used therapeutically.

Current Management of Valvular and Congenital Heart Disease

January 20, 1971 — Indianapolis

Continuing advances in diagnostic techniques and surgical therapy for valvular and congenital heart disease demand ongoing education in the management of these diseases. This course presents the latest methods for detecting potentially correctable valvular and congenital heart problems, reviews the natural history of these diseases, outlines the current criteria used for recommending surgery, and discusses the current surgical management of these conditions.

Urology for the Family Practitioner

February 17, 1971 — Indianapolis

This course deals with urological problems which require a decision at the family practice level. Pediatric problems discussed will include: sex assignment in genital ambiguity; management of recurrent urinary tract infections, with special reference to the problem of reflux; appropriate management in undescended testis; and management of hypospadias. Among adult urologic problems, attention will focus on: the etiology of renal calculus disease; renal hypertension, its workup and management; masses of the testicle — the role of surgery, radiology, and chemotherapy in the management of testicular carcinoma.

INDIANA

March

Indianapolis

Electrocardiography for Physicians — 22nd Annual Course
3/3-5/71
Common Endocrine and Metabolic Problems
3/17/71
Anatomical and Clinical Otolaryngology — 56th Annual Course
3/28/71 to 4/9/71

April

Plymouth

Psychiatric Problems in General Practice
4/7/71

Indianapolis

Contemporary Clinical Pathology and the Referral Facility
4/21/71

Lafayette

A Symposium on Trauma Emergency Care
4/22/71

May

Indianapolis

Sixth Annual Indiana Multidisciplinary Child Care Conference
5/5-6/71

June

Indianapolis

Emergency Medical Care
6/2/71
Membrano-Bound Enzymes
6/9, 10, 11/71

January

ILLINOIS

Belleville

Course 1—Clinical Anesthesia Practice
1/4/71 to 2/3/71

MICHIGAN

Eloise

Inhalation Therapy Conference
1/15/71 to 1/16/71

Detroit

Regional Anatomy (Anatomy of Back and Limbs)
1/71 to 3/71
Regional Anatomy (Anatomy of Head and Neck)
1/71 to 3/71
Regional Anatomy (Anatomy of Trunk)
1/71 to 3/71
Air Sampling and Analysis
1/71 to 3/71
Statistical Applications in Industrial Hygiene
1/71 to 3/71
Applied Radiologic Physics in Diagnostic Radiology and Radiation Therapy
1/11/71 to 3/27/71
Clinical Applications of Nuclear Medicine I & II
1/13/71 to 6/16/71

Grosse Pointe

Recent Advances in Clinical Medicine
1/7/71 to 3/11/71

MINNESOTA

Minneapolis

Common Urological Problems
1/18/71 to 1/20/71

OHIO

Cincinnati

Selected Aspects of General Medicine
1/20/71 to 1/21/71
Recognition, Evaluation, and Control of Occupational Hazards
1/18/71 to 1/22/71
Urology — X-Ray Seminar
1/71

Cleveland

Antibiotic Susceptibility Testing
1/25/71 to 1/27/71
50 Years of Surgical Progress
1/13/71 to 1/14/71
New Developments in Special Procedures Complications & Legal Implications
1/27/71 to 1/28/71
Orthopedic Challenges — Reconstructive & Post Traumatic
1/20/71 to 1/21/71

INDIANA MEDICAL BUREAU
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A Licensed Employment Agency
Specializing in Medical Personnel

Our 20th Year Of Service

FUTURE MEETINGS, SEMINARS, COURSES

Medical Work-up Symposium Set at Kentucky Feb. 25-27

"Modern Methods for the Medical Work-up" is the subject of a symposium at the University of Kentucky in Lexington on February 25 to 27. This is the second of a series and will explore ways to improve efficiency of the practitioner. The subject matter will include collecting, analyzing and evaluating medical histories, physical examinations and laboratory data on patients. The registration fee is $125.- Further information is available by writing Dr. Frank R. Lemon, University of Kentucky, Lexington 40506.

Two AMA Lectures Scheduled

The AMA Lecture Program in the Medical Sciences announces two more lectures in Indiana schools. Dr. Laurence Hursh will visit DePauw on Thursday, January 7 and Dr. Richard Jones will speak at Goshen College on Monday, February 1.

Society for Cryosurgery To Meet in Florida

The Society for Cryosurgery will hold its regular meeting March 1 to 6 at the Diplomat Hotel and Country Club in Hollywood, Florida. An outstanding group of speakers will present papers. For more information write the Society at 30 N. Michigan Ave., Chicago 60602.

NYU To Conduct Rehabilitation Course

The New York University Medical Center will conduct a comprehensive course on "Rehabilitation in Chronic Lung Diseases" on March 1 and 2. The tuition is $100. Registration is limited. For an application write Dr. Edward H. Bergofsky, NYU Institute of Rehabilitation Medicine, 400 E. 34th St., New York City, 10016.

Mediclinics Refresher Course Set for March 8-18 in Florida

The Sixteenth Annual Mediclinics will conduct a postgraduate medical refresher course in Fort Lauderdale, Florida, from March 8 to 18. Headquarters will be the Galt Ocean Mile Hotel. The course is sponsored jointly by the Florida Academy of General Practice and the Broward General Hospital. It is accepted for 32 hours of credit by the AAGP. The registration fee is $100. Write Mediclinics, 832 Central Medical Bldg., St. Paul, Minn. 55104.

Medicolegal Symposium Set by ABA-AMA

The National Medicolegal Symposium, sponsored by the American Bar Association and the American Medical Association will be held at the Americana Hotel, New York City, on March 18 to 20. The program subjects will be "Can We Survive Environmental Pollution?" "The Malpractice Crisis," "Tax Tips for Professional Men" and "The Population Explosion." To pre-register write Liaison Committee to ABA, 535 N. Dearborn, Chicago 60610.

Rural Health Conference To Be Held in Atlanta

The 24th National AMA Conference on Rural Health will be held at the Marriott Motor Hotel in Atlanta, Georgia, on March 25 and 26. The theme will be "Community Health Programs for Tomorrow." Write the Council on Rural Health, 535 N. Dearborn, Chicago 60610.

12th Postgraduate Seminar, West Indian Cruise Combined

The Department of Postgraduate Medicine of Albany Medical College announces reservations are now being accepted for the Twelfth Postgraduate Medical Seminar Cruise January 5-20, 1971.

A 15-day cruise from New York aboard the luxurious and distinguished ship "Gripsholm" of the Swedish American Line.

Ports of call include San Juan, Dominica, St. Vincent, Trinidad, Barbados, Martinique, and St. Thomas.

Faculty of the Albany Medical College will present a comprehensive shipboard postgraduate program, covering subjects in internal medicine, cardiology, oncology, psychiatry, surgery, and obstetrics and gynecology.

Request has been made for continuation study credit by the American Academy of General Practice.

For information write to: Girard J. Craft, M.D. Department of Postgraduate Medicine, Albany Medical College, Albany, N.Y. 12208.

Diabetes Clinical Conference To Be Held at Rochester

The Mayo Clinic will hold its "Diabetes in Review Clinical Conference" at the Kahler Hotel, Rochester, Minn., on January 20, 21 and 22. The fee is $75 for members of the American Diabetes Association and $100 for nonmembers. Residents and interns are accepted without charge. The course is acceptable for 17 hours of elective credit by the AAGP. Programs and registration forms may be obtained by writing the American Diabetes Association, 18 E. 48th St., New York City 10017.

Cleveland Clinic Lists 1971 Courses

Postgraduate Courses at the Cleveland Clinic for the first part of the New Year will be "Orthopaedic Challenges—Reconstructive and Post Traumatic" on January 20 and 21; "Complications of Angiography and Other Special Procedures and Their Legal Implication" on January 27 and 28; and "General Practice" on February 3 and 4. The fee for the first two courses listed is $60. The "General Practice" Course is acceptable for 7½ hours Category 1 credit by the AAGP. Its fee is $45. For registration write the Clinic at 2020 E. 93rd St., Cleveland 44106.

The Woman's Auxiliary

REPORTS TO ISMA

The only thing that seems to be foremost on my mind is to wish all of you a HAPPY HOLIDAY SEASON.

It is always an exciting time of the year and a time when my activities slow down a bit as far as Auxiliary work is concerned. This is the time to think of our families first.

It also means I have reached the middle of the road so to speak, the half way mark in my year as President. It has been a lot of work and a lot of fun. The best part being the making of many new friends.



Lelia Chernish and I had a busy fall. We went to the Fall Conference in Chicago and on to the ISMA meeting in South Bend and back to Chicago for the North Central Regional Workshop. We learned a great deal at the meetings, some of which we hope to convey when we are guests at the County auxiliary meetings around the State.

We were certainly royally treated in South Bend at the ISMA activities for the men and women. We so enjoyed the luncheon and the tour of Notre Dame and the art lecture. We had loads of fun at the Gaslight party and were sorry we couldn't attend the president's luncheon on Thursday but due to all the conflicting dates we had to return to Chicago.

In traveling over the state these past few months I have seen the interest of the women in legislation. Of course it is our future, too, which is at stake and we are trying to work and help our husbands' future as much as possible. We must stay informed and involved in all aspects of our community to help the health and future of this country.

I want to thank all of you again for all the cooperation I have received; certainly it is most appreciated.

Again I want to wish you all a Very, Very HAPPY HOLIDAY SEASON.

Doris M. Clouse

What's New?

Techniques for clinical cytopathology according to the Millipore technique are described in a 33-page booklet prepared by Gary W. Gill, Chief Research Associate of Johns Hopkins. Copies of the booklet may be obtained without charge from the Millipore Corporation, Bedford, Mass. 01730.

* * *

Cenco has a new, non-irritant, sterile, disposable, surgical scrub sponge which may be obtained with either detergent plus hexachlorophene or iodophor impregnation. The sponges are marketed in dispenser boxes of 40 each. The boxes are suitable for wall mounting.

* * *

Block Engineering has introduced a new intravenous monitor which counts the drop rate and monitors the level of the fluid in the bottle. It produces a warning signal when the drop rate varies and when only 25 cc. of solution is remaining.

* * *

The Posey Company of Pasadena, makers of a grand variety of medical and surgical supplies and gadgets, has a new catalog out. It describes the complete line of more than 200 items, including 35 items which are new this year. A free copy is obtainable. Write Posey at 39 S. Santa Anita Ave., Pasadena, Calif. 91107.

* * *

Technicon® is displaying an AutoTyper® which will automatically determine ABO and Rh type and group. With change of reagents samples may be rerun for rare antigens. The device not only saves much time for the busy technician but also is very economical with antisera and requires less than manual methods. It is hoped that blood bank services may be expanded because of the economies afforded. Routine admission typing, community wide blood typing and antibody screening programs are suggested as possibilities.

* * *

Robins has a new cough/cold formulation, Dimacol™ offered for the management of cough, mucosal congestion, edema, and nasal hypersecretion. Dimacol will be in the form of capsules or chocolate-flavored liquid. Ingredients are pseudoephedrine hydrochloride, pheniramine maleate, dextromethorphan hydrobromide and glyceryl guaiacolate.

* * *

"Doctors on Horseback," the story of seven pre-Civil War doctors who became world famous, written by James T. Flexner in 1937, has been republished by Dover. The new issue is unabridged, has new bibliographical material, 10 illustrations and an index.

* * *

Beta Engineering has three new low-cost monitoring units for medical use. VEINGUARD is a warning device which gives an alarm when the fluid level in an infusion bottle reaches a predetermined level. DROPGUARD monitors automatically the drop rate for liquids. UROGUARD emits an alarm when a catheter or drainage tube ceases to drain liquid. The devices were designed to eliminate unnecessary manual adjustments and time consuming surveillance procedures.

* * *

Posey has a Safety Lap Robe which keeps the patient's legs and feet warm while sitting in a wheel chair. The robe's waist belt holds the occupant against the back of the chair in addition to keeping the robe in place. There is a strap across the knees to prevent forward sliding movement. Also there is a shoulder "Y" strap to prevent the patient from slumping forward. It is washable. Comes in one size which is adjustable to all patients.

* * *

Doubleday has published "Potions, Remedies & Old Wives Tales" by W. W. Bauer, M.D. Beliefs and practices, both valuable and useless, are examined. The result is a humorous and authoritative folk medicine study and an interesting look at thousands of years of superstition. 336 pages for $5.95.

* * *

Ames has a new dip stick which detects six different factors in the urinalysis. A single clear plastic strip tests for pH, proteinuria, glycosuria, ketonuria, bilirubinuria and hematuria. The color change occurs within 30 seconds and can be compared with a color chart on the bottle label.

* * *

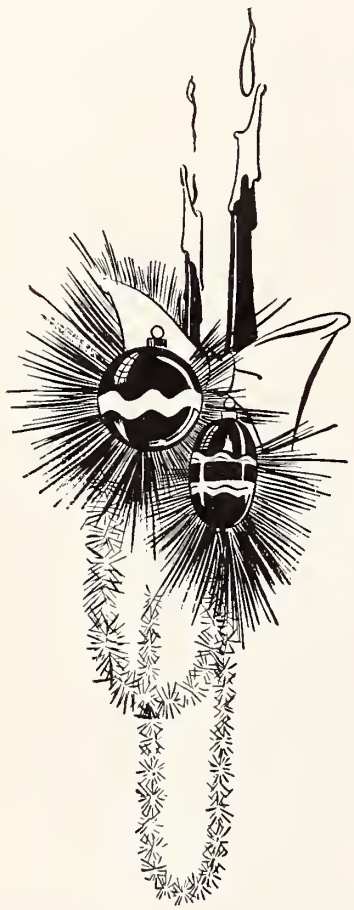
A new portable automatic artificial kidney is announced by Milton Roy Company of St. Petersburg. It resembles a table-top television set and weighs only 149 pounds. All operating cycles are automatically programmed and the system includes complete monitoring and alarm protection. It automatically compensates for fluctuations in temperature, pressure, electrical current, and dialysate concentrate. It sells for just below five thousand, f.o.b. Florida.

* * *

Lilly introduces a new antibiotic which is effective against bacterial infections of the urinary tract. Kafocin® is from the cephalosporin family and is the first of the derivatives to be recommended for oral administration. It is active against susceptible strains of Escherichia coli, Klebsiella-Aerobacter, staphylococci, certain of the Proteus species and enterococci, but not against Pseudomonas. Diarrhea is the most frequent adverse reaction. Prolonged use may result in overgrowth of nonsusceptible organisms.

* * *

Cenco is marketing a disposable sitz bath unit which will fit into the bathroom john or into a bedside commode. It is priced economically enough to allow only single patient use, thus reducing danger of cross infection. If used in the hospital, the bath unit may be taken home for further use by the patient.



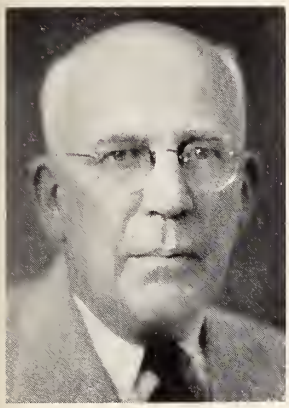
The editor and the staff of
The Journal wish you all
a Very Merry Christmas and
a Happy New Year



Deaths

Walter U. Kennedy, M.D.

Dr. Walter U. Kennedy, 92, New Castle, first president of the Indiana Blue Shield Plan and a former president of the Indiana State Medical Association, died Oct. 20 at the Henry County Hospital.



A graduate of Barnes Medical College, St. Louis, he interned in Berlin, Germany. He later was professor of surgery at Barnes. During World War I he was surgical chief and commanding officer of Base Hospital 106 of the American Expeditionary Force.

He was a past president of the North St. Louis and Tri-State Medical societies before moving to New Castle. He served as president of the Sixth District and Henry County medical societies.

In 1955 Dr. Kennedy served as ISMA president and served on the board of trustees for a number of years. He had been a member of the New Castle State Hospital advisory committee.

Richard M. Anderson, M.D.

Dr. Richard M. Anderson, 62, Vincennes physician and surgeon, died Nov. 6 in Good Samaritan Hospital, Vincennes.

He had practiced at Vincennes since graduation from Washington of St. Louis Medical School in 1934 and following internship at Columbus, Ohio. He was a past president of the Knox County Medical Society and was a member of AMA, the International College of Surgeons and the American Society of Abdominal Surgeons.

Ralph W. Dreyer, M.D.

Dr. Ralph W. Dreyer, 63, Richmond, died Nov. 1 in Reid Memorial Hospital, Richmond.

He had practiced in Carthage and moved to Knightstown in 1940, where he had a private practice and also served as the physician at the Indiana Soldiers and Sailors Children's Home until 1953. From 1953 to 1955 Dr. Dreyer served as a lieutenant commander in the U. S. Navy. In 1955 he moved to Richmond, discontinuing private practice in 1965 to devote full time to an industrial practice. A graduate of the University of Louisville Medical School, he had served as Henry County coroner for eight years and also as Wayne County coroner for eight years. He was a member of the Wayne-Union County Medical Society.

Norman L. Heminway, M.D.

Dr. Norman L. Heminway, Elkhart, former medical director of the Ames Company, died Nov. 15 at Elkhart General Hospital. A graduate of the University of Pennsylvania Medical School, he came to Elkhart in 1955 and was with Ames until 1964.

A member of the AMA and of the Elkhart County Medical Society, he was also a member of the New York Academy of Science, American Association for the Advancement of Science and numerous related organizations.

James W. Jackson, M.D.

Dr. James W. Jackson, 90, retired state epidemiologist, died Nov. 19 at Marion. For 40 years he was with the State Board of Health, retiring in 1955.

He was a graduate of the Indiana University School of Medicine. A senior member of the Indiana State Medical Association, he was also a member of the Marion County Medical Society and a 50-year member of the I.U. Emeritus Club.

Robert J. Masters, M.D.

Dr. Robert John Masters, nationally known Indianapolis ophthalmologist, died Oct. 30 in his home. He was 76 and had practiced medicine for more than 54 years.

From 1943 until 1954 he headed the department of ophthalmology at the I.U. School of Medicine, having served on the faculty for several years. In addition to teaching at I.U., he annually taught courses at the American Academy of Ophthalmology. He was an instructor in postgraduate courses at Colby College, Lancaster, Me. Dr. Masters was a member of the AMA and former chairman of the section on ophthalmology. He was a former director of the American Board of Ophthalmology and was a fellow of the American Academy of Ophthalmology and Otolaryngology. He was also a member of many other professional groups, including the Marion County Medical Society.

A daughter of Dr. Masters is married to United States Secretary of Defense Melvin R. Laird.

James B. Maple, M.D.

Dr. James B. Maple, 91, long-time necrologist for the ISMA, who practiced at Sullivan for more than 60 years, died Nov. 2 at Mary Sherman Hospital.



A former secretary and historian of the Sullivan County Medical Society, he served as president in 1907 and 1924. In 1936 Dr. Maple wrote a history of the society.

In 1955 he was named Physician of the Year by the ISMA. A medical milestone was observed by Dr. Maple on Oct. 12, 1953, when he delivered his 4,000th baby.

Joseph Ricketts, M.D.

Dr. Joseph W. Ricketts, 87, retired proctologist and former Indianapolis resident, died Nov. 4 in the Chicago area.

A graduate of the University of Maryland School of Medicine, he was certified by the American Board of Surgery and by the American Board of Colon and Rectal Surgery. He was a member of the Marion County Medical Society and the AMA.

A. M. Winklepleck, M.D.

Dr. A. M. Winklepleck, 91, who had retired in 1959 after more than 50 years in the tuberculosis field, died at Fayette Memorial Hospital, Connersville. He was an honorary member of the Fayette-Franklin County Medical Society and in 1965 became a member of the ISMA 50-Year Club.

Dr. Winklepleck was a graduate of the I.U. School of Medicine and interned at Indianapolis City Hospital; he served as superintendent and medical director at several sanatoriums and tuberculosis hospitals. When he retired, he had been tuberculosis control physician at the Logansport State Hospital five years.

County, District News

Allen

When the Allen County Medical Society held its November meeting the speaker was Bertram M. Winer, M.D., assistant clinical professor of medicine at the Harvard Medical School. His topic was "Advances in Hypertension."

Carroll

Thomas Fouts, D.D.S., of Delphi, discussed "Relative Analgesia" at the November meeting of the Carroll County Medical Society. Attendance was 100% for both members and their spouses.

Dearborn-Ohio

Nine members and three guests were present when the Dearborn-Ohio County Medical Society met recently at the Dearborn Country Club at Aurora. Mrs. Pettus of the State Board of Health spoke on the duties of a public health nurse.

Elkhart

"Visual Aids for the Partially Sighted" was the topic chosen by Alfred A. Fontana, O.D., Chicago, Ill., when he spoke at the November meeting of the Elkhart County Medical Society.

Fayette-Franklin

Dr. William McSweeney from Cincinnati Children's Hospital addressed members of the Fayette-Franklin County Medical Society on November 10 at the Connersville Country Club. His topic was "Pediatric Radiology."

Fountain-Warren

A review of the 1970 convention by Dr. Max Hoffman was a feature of the November meeting of the Fountain-Warren Medical Society meeting.

Hancock

Dr. Edward Gabovitch of Indianapolis spoke on "Management of Rheumatoid Arthritis" at the October meeting of the Hancock County Medical Society. Eighteen members plus three dentists were present, as well as wives.

Hendricks

Fourteen members were in attendance at the October meeting of the Hendricks County Medical Society.

Jay

A talk on "Cross-Eyed Children" was given by Dr. Richard Parrish of Decatur at the November meeting of the Jay County group at the Portland Country Club. Fourteen members and their wives were present.

Miami

The bimonthly meeting of the Miami County Medical Society was held at Peru on November 17. The election of officers resulted in the re-election of all present officers. Dr. Donald W. Ferrara continues as president, Dr. James U. Guthrie, vice president, and Dr. Lloyd Hill, secretary. Dr. Hill was also re-elected delegate. Dr. Gordon C. Crates was named to a three-year term as a censor.

Montgomery

Dr. William Sholty, new Ninth District Trustee, attended the November meeting of the Montgomery County Medical Society at Culver Hospital, Crawfordsville. Eighteen members attended.

Parke-Vermillion

The November meeting of the Parke-Vermillion County Medical Society featured a discussion of week-end emergency care at the local hospital to be covered by Union Hospital beginning December 1.

Rush

At the October 30 meeting of the Rush County group at the Rush County Hospital there was a discussion with regard to hiring medical students to operate the emergency room under the supervision of an M.D. Seven members were present.

Shelby

Eighteen members heard Dr. John Records of Franklin speak on "Drug Abuse" when the Shelby County Medical Society met on November 5 at the Major Hospital, Shelbyville.

Tippecanoe

President-Elect Peter J. Petrich of Attica was a guest at the November meeting of the Tippecanoe County group. One hundred thirty-four were in attendance, including wives and medical students. Dr. C. L. Waits was elected president; Dr. Jack Burns, vice president; Dr. R. E. Hannemann, secretary; and Dr. David L. Evans, treasurer. Delegates chosen were Dr. Wallace Van Den Bosch (3 years), Dr. George Underwood (3-year alternate) and Dr. Ramon B. DuBois (2-year alternate).

Association News

BOARD OF TRUSTEES

October 12, 1970

The Board of Trustees met in Randall's Inn, South Bend, at 2:00 p.m., Monday, October 12, 1970.

Roll call showed the following:

District	Trustee	
1	G. M. Wilhelmus	Present
2	Joe Dukes	Present
3	Donald M. Kerr	Present
3	Eli Goodman (Elect)	Absent
4	Robert Reid	Present
5	Wilbert McIntosh	Absent
6	Stephen Smith	Present
7	James Gosman	Present
7	Dwight Schuster	Present
8	Richard Ingram	Present
9	Peter R. Petrich	Present
9	William Sholty (Elect)	Present
10	Vincent Santare	Present
11	Lowell J. Hillis	Present
12	William R. Clark	Present
13	Otis R. Bowen	Present

District	Alternate Trustee	
1	Eugene W. Austin	Absent
1	Raymond Newnum (Elect)	Absent
2	Betty Dukes	Present
3	Elmer Wallace	Absent
4	Jack Shields	Present
5	Cleon Schauwecker	Absent
6	Paul M. Inlow	Present
7	John O. Butler	Present
7	Joseph Kerlin	Absent
8	Paul Sparks	Absent
8	Robert Williams (Elect)	Absent
9	Lindley Wagner	Absent
10	Thomas C. Tyrrell	Present
11	James Harshman	Present
12	Frederic Schoen	Present
13	G. Beach Gattman	Present

Officers:

Lowell H. Steen, Hammond, president — Present

Malcolm O. Scamahorn, Pittsboro, president-elect — Present

Lester H. Hoyt, Indianapolis, treasurer — Present

Hugh K. Thatcher, Indianapolis, assistant treasurer — Present

Journal:

Frank B. Ramsey, Indianapolis, editor, Present

Executive Committee:

Donald M. Kerr, Bedford, chairman — Present

Burton E. Kintner, Elkhart, Member — Present

Delegates and Alternate Delegates to AMA:

Don E. Wood	Absent
Eugene Senseny	Absent
Frank Green	Present
John Farquhar	Absent
Jack Shields	Present
James Harshman	Present
Eugene Rifner	Absent
Kenneth Neumann	Present
P. J. V. Corcoran	Absent
Thomas Tyrrell	Present

Guests:

Glenn W. Irwin, dean, I.U. School of Medicine; Joseph Davis, chairman, executive committee RMP; Peter Foster, president, Indiana Chapter, Student AMA.

County Society Executive Secretaries:

Larry Pickering, John Twyman, Polly Dent, Arthur Loftin, Harry Davis.

Staff:

Howard Grindstaff, Field Secretary
John Walters, Field Secretary
Kenneth W. Bush, Administrative Assistant
James A. Waggener, Executive Secretary

Minutes of the meeting held September 12th and 13th were approved.

DR. SCAMAHORN: I plan to conduct the new AMA Leadership Training Program, which is a day and a half in length, beginning at 9:00 a.m. and ending at 5:00 p.m. - one full day and the following day from 9:00 a.m. to noon. The purpose is to build self-confidence in leadership and leadership skills. I feel that this would be good training which would help us to develop high performance of voluntary leadership. This will be one of the first states to take advantage of this new program which is being offered by the AMA at no cost to our association. We could have it either on a mid-week day or on a weekend. I would ask for a show of hands of those who would prefer a weekday and those who would prefer a weekend.

The show of hands indicated a weekend was the choice of the Board. Unless you object, I am going to ask that the commission chairmen be offered this program, and if you have no objection, to offer it to the officers of the Woman's Auxiliary. With your permission, I will proceed with plans for conducting this program on the 16th and 17th of January.

The treasurer reviewed the investments, income and expenses for the month and the unaudited financial report for the year.

CHAIRMAN: We will now hear the report from the Editor of the *Journal*, Dr. Ramsey.

DR. RAMSEY: As Dr. Hoyt has indicated, the financial status of the Journal came out very close to the budgeted figure. While the advertising income dropped below that anticipated, the income for reprints exceeded our expectation and it is impossible to predict what the advertising income will be for the coming year. We have to plan the *Journal* month by month on the basis of advertising because in those months in which advertising is less, the only thing we can do is to reduce the total number of pages in the *Journal*. We have enough scientific articles to take care of almost the next twelve publications of the *Journal*.

CHAIRMAN: We will now move to matters referred by the Executive Committee to the Board of Trustees.

DR. KERR: The Executive Committee met at 10:00 a.m. and on through lunch and we considered some fifty items. Of those, the following were considered worthy of the time and attention of the Board. You will recall there was a resolution from the Woman's Auxiliary to include their dues on the membership dues of the association. There were questions as to the legality of this procedure and there had been a request that there be reports from consultants in the accounting field relative to this matter. I have here a reply from George S. Olive Company, our auditors, which pointed out that they believed the auxiliary dues could be colleeted without endangering the tax status of the association. However, they pointcd out that this would probably not be a deductible item for this portion of the dues by the members under present IRS ruling. This arrangement of course would create additional bookkeeping as well as timc involved in reconciling members records, not only of our association but of the auxiliary. The Board previously took action that this resolution be rechecked but I thought you should have the information contained in this letter as confirmation of the rightness of your decision.

DR. INGRAM: **I move that we deny the request for auxiliary dues to be**

included on the state dues billing.

The motion was discussed, put to vote and carried.

DR. SCHUSTER: **I move that we adopt this motion of collecting the dues for the auxiliary in order to help build up their membership.**

The motion was seconded by Dr. Gosman.

DR. SANTARE: As I understand it this will be optional—it will be put on all dues notices that are sent but will be optional to be paid by the members.

The motion was then discussed by Dr. Shields and Dr. Wilhelmus.

CHAIRMAN: **The motion was made to table, put to vote and carried.**

DR. KERR: We have a letter from SAMA in reference to the MECO project. If you will recall you have all had a report on this and it is now pointed out that in order for the Indiana group to go ahead with this project they need approval of the State Medical Association. Dr. Gosman was to report on this and I would ask him if he is in a position to report on this at this time.

DR. GOSMAN: I still feel as I did before that we should not accept this recommendation of the SAMA organization. **Therefore, I move that we do not approve it.**

CHAIRMAN: **Is there a second? There being none, the motion dies for lack of a second.**

DR. KERR: Perhaps I should read the letter.

Dr. Kerr then read the letter from the SAMA organization.

DR. STEEN: I move that we either alter the agenda in such a way to hear from Mr. Foster now or defer this until after his report.

CHAIRMAN: We will hear from Mr. Foster at this time.

MR. FOSTER: I consider it a privilege to be asked to speak to you. I regret that this is the only day I will be able to attend any sessions of the annual meeting. As you know, SAMA was granted two seats in a non-voting capacity in your House of Delegates. There will be two seniors representing our organization attending these meetings. They are here not only to learn from the proceedings but to participate and I hope you will feel free to ask them any questions you have as to our personal viewpoint or the viewpoint of medical students in general concerning the issues discussed in this convention. We, as a student medical organization, are facing much the same problems as you face. Not only has our membership been gradually decreasing, but interest and participation has reached an all-time low. Whether this is disdain of new students for organized medicine in general or distrust of older and more established physicians, I cannot say, but I feel this is a problem we face and one of my objectives is to re-establish interest in this facet of medicine.

One prospect for doing this currently is MECO. This was established two years ago and has been operating in fifteen states. Last summer, for instance, in Illinois 55 hospitals participated in the program, involving some 141 medical students. Most of these students participated in the program following their freshman year. The program, in general, consists of about 10 weeks during the summer vacation in which they worked in the hospital under the leadership of a physician for a stipend provided by the hospital or monetary funds derived from other sources. The students rotated to the different departments working with one physician in each. In this way, the student becomes interested and attuned to medicine as practiced in local and small town hospitals, hopefully influencing his choice of a location in which to practice. We are currently working with the hospital association to obtain their interest, in order that we might implement this program. We feel this program is well worth your support. I would add that it might be possible to do as I understand has been done in some other states — that is, to establish two different types of externships, one aimed at freshmen and one for those who have begun their clinical medicine. As you may know, the externships offered in Indianapolis hospitals are all completely taken by the group that starts their sophomore year, so that the students who do not apply for it the summer of their freshman year are likely to be left out in the cold. Probably 75% of the sudents do not have any kind of an externship and in those cases most of them would like to have one.

I have informed Mr. Waggener of the interest of three students to become active in attending your various commission meetings. Dr. Scamahorn has consented to talk to our next meeting scheduled for October 20th and I would like to offer my services in any way I can to help present the medical school community any ideas or programs which you might have in mind. We live in a time when the threat of government controlled medicine looms in the shadows as a real possibility. Only by acting as an organized group to instigate changes ourselves, which are direly needed, can we thus maintain the practice of medicine in a manner not controlled by others.

The matter was discussed by Dr. Frank Green, Dr. Glenn Irwin, Dr. Steen, Dr. Gosman, Dr. Hillis, Dr. Kerr, Dr. Clark, Dr. Harshman and Dr. Santare.

A motion was then made by Dr. Kerr to approve the program, seconded by Dr. Santare, put to vote and carried.

DR. KERR: The next matter to be referred was that we had a request from Dr. Reid relative to the leasing of space in the state office building pertinent to his operation of Medi-Tech. I will ask Dr. Reid to explain what he has in mind.

Dr. Reid explained that he would propose renting the space in the association building for the housing of Systems Evaluation Staff.

The matter was discussed by Dr. Shields, Dr. Wilhelmus, Dr. Reid, Dr. Kerr, Dr. Gosman and Dr. Steen.

Upon motion of Dr. Steen, seconded by Dr. Santare, request was denied.

DR. KERR: The next matter was that of the RMP program. You will recall this Board took action to withdraw the support of ISMA of this program. The matter was discussed again today. We again refer it to the Board for any action you may deem necessary at this time.

The matter was discussed by Dr. Irwin and Dr. Gosman.

DR. GOSMAN: **I move that this matter be deferred at this time until the two Executive Committees can get together for a discussion of their differences. Seconded by Dr. Schuster.**

The motion was then discussed by Dr. Ingram, Dr. Irwin, Dr. Kerr, Dr. Davis and Dr. Wilhelmus.

CHAIRMAN: **The motion to defer was put to vote and carried.**

DR. KERR: The next matter referred to the Board was correspondence from the Lake County Medical Society relative to the distribution of the reports of the actions of the Board of Trustees to be distributed to all members of the association rather than just to the trustees, delegates to the ISMA and county society officers. The Executive Committee feeling was that this would involve considerable expense and was not exactly a valid move. It was suggested in our meeting that these reports be made available to county societies who do want them in bulk for distribution at their own expense. We report this to you for your information and in order for approval or alteration of the position taken by the Executive Committee.

Dr. Hillis moved to approve the action of the Executive Committee; seconded by Dr. Santare, put to vote and carried.

DR. KERR: I would like to report that for this meeting 59 exhibit spaces have been sold for a total income of $14,200. The Executive Committee is attempting to bring out again that Indianapolis, on an economic basis if nothing else, seems to be the logical and reasonable place to have our annual meeting. This is given to you for your information only.

DR. KERR: Another matter referred to this Board from the Executive Committee is a wire from the California Medical Association pertinent to the Bennett amendment, as proposed in Congress. Dr. Kerr then read the telegram from the California Medical Association urging action on the part of the Indiana State Medical Association to defeat this amendment.

There was no action on this report.

DR. KERR: The next item referred to the Board is a letter from a group of minority students regarding the establishment of a Lewis B. Russell Scholarship fund to the medical school. The Executive Committee recommends that they be informed that there is no money available at this time and that we do have a student loan fund available at this time which is available to all and that we would be glad to allow them to use our mailing list to request all physicians in the state for donations and that publicity of this matter be given in the *Journal*. The president-elect will so notify the writer of this action unless you have objections. There being no objection, the matter was taken as approval of the Executive Committee action.

CHAIRMAN: Thank you, Dr. Kerr. I call your attention to the matter in the agenda—that of correspondence between the president and the director of the Department of Welfare dealing with the suggestion of HEW to publish and make available to Medicaid recipients the names of providers of medical care.

DR. SCAMAHORN: **I move that we adopt the policy as outlined by Dr. Steen in his letter to Mr. Sterrett; seconded by Dr. Ingram, put to vote and carried.**

CHAIRMAN: At this time I would like to make assignments for coverage of the various Reference Committees. Upon polling the Board, Reference Committee #1 will be attended by Dr. Reid, Dr. Bowen and Dr. Hillis; Committee #2 will be attended by Dr. Santare, Dr. Wilhelmus and Dr. Hoyt; Committee #3 will be attended by Dr. Gosman, Dr. McIntosh and Dr. Kerr; Committee #4 by Dr. Ingram, Dr. Schuster and Dr. Kintner; Committee #5 by Dr. Clark, Dr. Smith and Dr. Thatcher.

CHAIRMAN: We will pass up the reports of the commissions and committees; also the resolutions which we have previously reviewed and we will now read the new resolutions beginning with 70-32. I will call your attention to resolution 34 which is not really an appropriate resolution, in view of the fact that Mr. Waggener has correspondence from the Bureau of Motor Vehicles stating that this form that is talked about in this resolution is no longer available at local licensing branches and the Bureau has asked all license branches to discontinue the use of the form.

The matter was discussed by Dr. Smith, Dr. Neumann, Dr. Hillis, Dr. Kerr, Dr. Ingram and Dr. Kintner.

CHAIRMAN: I propose that those who attend Reference Committee #4 be prepared to discuss this and also to ask Dr. Neumann to attend this meeting, inasmuch as this resolution comes from his district.

If there is no other discussion on the resolutions, we will move on to unfinished business. You will remember at the meeting of the Board on September 12th we had a report from Dr. James Kirtley regarding a form to be used by physicians in reporting handicapped individuals. Subsequent study of this has brought up some points on the back side of this form which might indicate that the usefulness of this information could become public knowledge. I have discussed this with Dr. Steen, who originally made the motion to endorse Dr. Kirtley's report and then advise our members that we have endorsed the use of this report.

DR. STEEN: **I move to reconsider our previous action on this report form.**

The motion was seconded by Dr. Kerr, put to vote and carried. The previous action was then reconsidered and further discussed by Dr. Steen, Dr. Schuster, Dr. Harshman, Dr. Kerr and Dr. Hoyt.

DR. HOYT: Point of order. By the adoption of this motion to reconsider, what we have now done puts this motion again before us, so we do have before us the previous motion which was made on September 12th that we approve the use of this form and so inform our membership.

CHAIRMAN: **We now have a motion to table. The motion was put to vote and carried.**

CHAIRMAN: We will now move to Board Committee reports. There is no additional report from the Board Committee on Medical Education. Item b —Board Liaison Committee with Blue Cross, Dr. Santare.

DR. SANTARE: I have no additional report but Dr. Harshman may have.

DR. HARSHMAN: In report A, as it was written here, it was stated we would have a report from Blue Cross as to final disposition of Resolution 69-12. I called them Wednesday, Thursday, and Friday and it should not surprise anyone that they did not have as yet a report to give us. They did state, however, that this is a number one item on the agenda of the joint meeting of the Executive Committees of Blue Cross and Blue Shield. When I called Friday, Mr. Kilborn was in Mr. Herod's office and there was a meeting of minds between Blue Cross and Blue Shield. Mr. Kilborn said (and I quote him correctly), he "would be receptive to this sort of thing, providing there was some assurance they would not get duplicate bills for services rendered." I feel that something will be worked out but it will be sometime before we have a definitive answer.

CHAIRMAN: Item c, Board Committee with Blue Shield, Dr. Dukes.

DR. DUKES: I would report that at the Blue Shield Conference in Chicago last week our President, Dr. Steen, presented and handled himself very well. There was a lot of talk about peer review and the gist of the meeting, as I got it, was that they are running scared.

CHAIRMAN: Report of Business Consultants for the Journal, Dr. Dukes.

DR. DUKES: As you have already heard three times, we are running in the red.

CHAIRMAN: Board Committee on Economic and Fiscal Matters, Dr. Wilhelmus.

DR. WILHELMUS: No report at this time.

CHAIRMAN: Joint Committee on Emergency Medical Services.

DR. INGRAM: No report.

CHAIRMAN: Joint Board Committee on Orientation of New Members.

DR. CLARK: No additional report.

CHAIRMAN: Ad Hoc Committee on Medical Use of Computers, Dr. Reid.

DR. REID: I would prefer to defer my report at this time as it is rather extensive and will perhaps be further dis-

cussed in one of the Reference Committees.

CHAIRMAN: Ad Hoc Committee on Education.

DR. GOSMAN: No additional report.

CHAIRMAN: I will then accept requests from the trustees for remission of dues or any reports they desire to make.

On polling the trustees, there were no reports or requests for remission of dues.

CHAIRMAN: We will move now to new business - the nomination for two members of the Trust Committee of the Indiana Medical Foundation to succeed Dr. Bibler of Indianapolis and Dr. Loren Martin of Indianapolis, whose terms expire October 31, 1970.

DR. HILLIS: I would like to nominate Dr. Bernard Hall.

DR. DUKES: I would like to nominate Dr. Bibler for re-election.

DR. KERR: **I move the nominations be closed and a unanimous ballot be cast for their election.**

The motion was put to vote and carried.

DR. SCAMAHORN: I had a request from Dr. Sprague Gardiner that we appoint an Ad Hoc Committee on Maternal and Child Care. He suggests that this be representative of several areas of medicine and points out that he is not requesting any funds from the association. He apologized that he was unable to be here to explain this personally. What is your wish?

DR. STEEN: **I move that such a committee be appointed in accordance with Dr. Gardiner's wishes.**

The motion was duly seconded, put to vote and carried.

CHAIRMAN: I would remind you of the Board dinner here in this room tonight. The attitude adjustment hour will start at 6:30 p.m. with dinner at 7:30 p.m. and the price is $10 per head. If you have not paid, please see Mr. Waggener and pay for your dinner. The next meeting of the Board will be at 8 o'clock Wednesday morning in this room and I hope that those assigned to attend Reference Committees will be prepared to report discussions of Reference Committees at that time.

I beg your pardon; we are not finished. There was no report from the President of the association to the Board of Trustees. He requested that his report be deferred until this time. I will now call on Dr. Steen.

DR. STEEN: It is too late for admonitions and messages. It has been a great honor to be President of ISMA. It takes a great deal of time to be President. It takes time not only from your practice but from one's personal activities. It takes a great deal out of you from the standpoint of trying to be an innovator, and attempting to offer some valid leadership to the organization. I thought you might be interested in a few statistics. Since I became the Chairman of the Board four years ago I have been out of my office 246 days in the last four years, 73 have been in 1970. My secretary, in the last year, has written for ISMA 781 separate letters. This does not include the letters written by state headquarters. We have a file for the four years with tissue copies about four feet long. We average four unexpected phone calls a week from either staff or from disenchanted or enchanted members who take precedence over whatever is going in the office, in addition to which there are a number of unannounced visitors who come by and interrupt the normal day. I might indicate to you that this has been a very pleasant time. During a portion of this service to ISMA was one of the most trying times of my life personally, and my association with the people on this Board was a great solace to me at that time. Since November of 1969 it has been a great and new joy to be here with you. I am going to miss you all. One of the most pleasant things about serving in this Board is getting to know all you people, who I now count as close personal friends. I am going to miss you and there is going to be a sad and empty feeling. I have genuinely enjoyed this association and the friendships made. I wish you all well. I want you all to continue to work as hard as you have for me for the officers that follow me. Don't forget what I have said many times: "When this ceases to be fun, quit, because it isn't your money, and it isn't your blood, and it isn't your livelihood." Thank you so much. It has been a pleasure serving you.

DR. GOSMAN: I would like for this Board to give consideration again to the election of a Speaker of the House. We have argued this back and all this, but it is a big job and I sometimes wonder if the president would not be in a better position if he were not Speaker of the House.

DR. STEEN: You might remember that I introduced this idea to the Board several years ago and got soundly defeated. I was toying with the idea of making this recommendation to the House this year. I really think this would be a very valid thing to do. In addition to the things Dr. Gosman has enumerated, it would provide continuity; for I would hope the Speaker would serve for more than one year. It would permit him to become an excellent parliamentarian. It would permit him to become expert in handling a large group of people. Presidents vary in their parliamentary knowledge and their ability to handle a meeting. We have seen it done well. We have seen it done badly. Time will tell how it goes this year.

In addition, it does allow for involvement at a very high level, on the part of actually two individuals - the speaker and the vice-speaker. There is no question about the fact that the president is very busy during the annual convention. I have been out of this room five times already, two of them to tape television interviews, and one about a phone call. When you are presiding over the meeting, it hampers your ability to speak to issues which I think is the duty and responsibility of the president to speak to. Kentucky Medical Association does have a speaker. It works very well. The president is at liberty to speak freely since he is about to be retired in a few days anyway. It gives him much more freedom of expression than having to preside over the meeting. Certainly after you have been president-elect for a year, and president for a year, you have your fingers on all the Association business if you have done your job. You are probably better informed about organized medicine at that point than you ever will be or ever were at any time in your life. I would urge that some mechanism be set up by the Board to get this idea through to the House. I can't think of anything bad about it - except that it deprives the president of the glory and honor of presiding over the meeting, which, quite frankly, I confess I do not consider a joy and honor. It is a hell of a lot of hard work to stand up there for four hours presiding over that meeting.

COMMENT: I agree with Dr. Steen and Dr. Harshman that we got into trouble before by trying to do something at the last minute.

DR. STEEN: I would suggest that we put it on the agenda of the Board meeting at the close of the annual session.

DR. SCAMAHORN: I, too, am in favor of this. I would like to ask that we have more or less a straw vote. Is anyone definitely or unalterably opposed to this?

The matter was further discussed concerning the structuring of the membership on the Board of Trustees and the fact that it would take another year to bring this matter before the House and

that it be presented to the Commission on Constitution and Bylaws to prepare the proper amendments to the Constitution to create the position of Speaker and Vice Speaker. The matter was further discussed by the Executive Secretary.

CHAIRMAN: I will entertain a motion that we refer this to the Commission on Constitution and Bylaws with the suggestion of the Board that they investigate and work out at the earliest opportunity proper wording and report back to the Board their opinion and findings relative to this subject.

The motion was duly made, seconded, put to vote and carried.

DR. CLARK: I want to commend Dr. Kerr for his report. It is one of the finest reports I have ever seen.

There being no further business the meeting was adjourned.

BOARD OF TRUSTEES

October 14, 1970

The Board of Trustees reconvened at 7:30 A.M., Wednesday, October 14, in Randall's Inn.

Roll call showed the following:

District	Trustee	
1	Gilbert M. Wilhelmus	Present
2	Joe Dukes	Present
3	Donald M. Kerr	Present
3	Eli Goodman (Elect)	Present
4	Robert Reid	Present
5	Wilbert McIntosh	Present
6	Stephen Smith	Present
7	James H. Gosman	Present
7	Dwight W. Schuster	Present
8	Richard Ingram	Present
9	Peter R. Petrich	Present
9	Wm. Sholty (Elect)	Present
10	Vincent J. Santare	Present
11	Lowell J. Hillis	Present
12	William R. Clark	Present
13	Otis R. Bowen	Present

District	Alternate Trustee	
1	Eugene W. Austin	Absent
1	Raymond L. Newnum (Elect)	Absent
2	Betty Dukes	Absent
3	E. L. Wallace	Absent
4	Jack Shields	Present
5	Cleon Schauwecker	Absent
6	Paul M. Inlow	Present
7	John O. Butler	Present
7	Joseph Kerlin	Absent
8	Paul Sparks	Absent
8	Robert D. Williams (Elect)	Present
9	Lindley Wagner	Absent
10	Thomas Tyrrell	Present
11	James A. Harshman	Present
12	Frederic Schoen	Present
13	G. Beach Gattman	Present

Officers:

Lowell H. Steen, Hammond, President — Present

Malcolm O. Scamahorn, Pittsboro President-elect — Present

Lester H. Hoyt, Indianapolis, Treasurer — Present

Hugh K. Thatcher, Indianapolis, Assistant Treasurer — Present

Journal:

Frank B. Ramsey, Indianapolis, Editor, — Present

Executive Committee:

Donald M. Kerr, Bedford, Chairman — Present

Burton E. Kintner, Elkhart, Member — Present

Delegates to the AMA

Don E. Wood	Present
Eugene Senseny	Absent
John Farquhar	Absent
Jack Shields	Present
Frank Green	Present

Alternate Delegates to the AMA

James Harshman	Present
Eugene Rifner	Present
K. O. Neumann	Present
P. J. V. Corcoran	Present
Thomas C. Tyrrell	Present

Guests:

Dr. Joe Black, Guy A. Owsley, Richard C. Kilborn, Mrs. Carole Rust, Dr. George Callender, Dr. McGue, Dr. Herman Baker and Tim Norbeck

Staff:

Howard Grindstaff
James A. Waggener

The Chairman introduced Dr. George Callender, President of the West Virginia State Medical Association; Dr. Herman Baker, the oldest living past president of the Association, and Timothy Norbeck, field representative of the American Medical Association.

CHAIRMAN: We will now hear from Dr. Guy Owsley, Chairman of the Council on Medical Services of the AMA.

Doctor Owsley reviewed some of the activities of the Council, some of them the result of the last meeting of the AMA and pointed out that the Council will have a meeting in Boston which, no doubt, will be another controversial conference, in which they will explore some of the ideas others have in the health care delivery system. Dr. Owsley touched upon their study on the committee on automation; multi-phasic screening; delineation of the leadership with the Sears Foundation program. He pointed out that they will also have an orientation conference for long term care during the Boston meeting. He also reported on the Ad Hoc Committee on Foundations, of which Dr. Steen is a member. This committee will investigate all types of foundations and report to the House of Delegates in June 1971. Dr. Owsley also discussed the peer review program pointing out that some are equating peer review with fee review when peer review should have nothing to do with fee review. He also discussed medicare payments to physicians of teaching institutions, Resolution 27—informing the public of source of related health care costs and recommendations—13 and 18 of the Himler Report; and Resolution 34, which requests a data collection program for the AMA.

CHAIRMAN: We will next hear from Dr. Black, Chairman of the Board of Blue Shield.

Dr. Black stated it had been a pleasure to work with the Board of Trustees and the officers on behalf of Blue Shield during the past year. He pointed out that, in spite of the criticism of the Blue Shield operation, he felt they were doing a good job and discussed his ideas for changes in the structure of the board as well as the limitation of the tenure of members of the board of directors of Blue Shield. He pointed out that the field staff of Blue Shield will be going out and calling on the county medical societies to discuss utilization review.

CHAIRMAN: If there are no questions, we will next hear from Mr. Kilborn, President of Blue Shield.

MR. KILBORN: I had the opportunity to make some remarks in one of the Reference Committees yesterday which I would like to repeat here, as some of you were not present in this particular Reference Committee. We were discussing Blue Shield progress in expanding our benefit coverage to a more elaborate program. This was partially due to Dr. Dukes' request to give him some data to present to this group. It was the first time I had gathered this particular data and it was interesting to me. What we did was compare the percentage of our people here in Indiana covered by these particular programs currently in effect. In comparing '65, '67 and '69 it was interest-

ing that we started out in 1965 with a total of 26.7 percent of our people under the usual and customary program. Under the preferred schedule we had about 42% of our members and under the standard program we had 30.4%. We progressed from that period to '69. Today we have 54.6% with the usual and customary program; preferred stayed just about the same, up from 41.8% to 42%. The standard schedule went down from 30.4% to 3% so as was promised the Board some years ago, we have discontinued the standard schedule. It is no longer available for sale.

DR. WILHELMUS: You made a comment yesterday about the percentage on diagnostic plan.

MR. KILBORN: In '65 we had 77% of our members with our diagnostic program and lab work outside the hospital. Today we have 90.37%.

QUESTION: Is there any way to find out what the exact cost will be to the employee in comparison to buying the usual and customary?

MR. KILBORN: We have priced the program and so has everyone else in the current legislation before Congress. I believe there are fourteen types of bills from the most extensive program, which has a price tag by their own admission of $34 billion the first year. The administration figures that the same bill is $77 billion dollars. In trying to break this down per person coverage I remember it figures something like $1,000 per person per family unit per year. None of our programs cost that kind of money today.

QUESTION: What is the most expensive program you have for entire families?

MR. KILBORN: The program with which we hope to experiment would be the most comprehensive and the actual cost would be $45 a month per family or $600 per year. The Foundation concept with which we are working would be of a comprehensive nature. The rate I quote is on an experimental basis as we really do not know what the total cost would be. In theory you would save money ultimately on the hospital side if the foundations and physicians in the foundation are effective in controlling hospital costs which would make up for the cost of additional coverage such as office calls, inoculations, and preventive care.

DR. GOSMAN: Yesterday you gave an explanation to one of the physician's questions where you described the three kinds of insurance. Would you repeat this?

MR. KILBORN: Actually there is only one usual and customary program, that is our regular business which we have in effect for U.S. Steel; General Motors; Ford and Chrysler. This comprises 55% of our population. We have two indemnity programs, Medicaid and Medicare. The government does not want to call them indemnity programs but that is what they are. The Medicaid program is based on the 75th percentile of the fees in effect as of January 1, 1969. The Medicaid program is based on the 83rd percentile of the fees that were in effect that same date.

QUESTION: What progress is being made on getting diagnostic and laboratory service out of the hospital and into the private physician's office and laboratory?

MR. KILBORN: The Blue Cross-Blue Shield executive committees have had one meeting and hope to have another soon. Frankly the chairman of the Blue Cross Executive Committee is involved in the G.M. negotiations and has been in Detroit since the beginning of the strike so we are having difficulty in getting all the parties together. We do intend to have a joint committee meeting again before the end of this year. One of the main subjects of the last one and that of the future meeting will be "How Can We Pool Funds" to accomplish the very things we are discussing. I think everyone has to realize that even if we can't work out a way jointly, Blue Shield would still be in a position and Blue Cross is in a position to go to an account and experiment with them.

If I may, Mr. Chairman, I would like to comment further by giving a report as to the time consumed for processing Medicaid and Medicare claims as I do have some accurate figures as of Monday, October 12th. On regular business, 88% of our claims are being paid between 11 and 20 days; 21-30 days for 6%; 31-60 days for 5% and over 60 days, 8%. Of our Medicare claims 66% are being paid the first 10 days; 8% 11-20 days; 8% 31-60 days; and 10% over 60 days. We have quite a problem of eligibility on Medicare and Medicaid. On the Medicaid program 51% are being paid in the first 10 days; 15% in 11-20 days; 8% in 21-30 days; 11% in 31-60 days and 15% 61 days or more.

CHAIRMAN: Thank you Mr. Kilborn. I will now call on Board members to report on the Reference Committee they attended. Dr. Gosman.

DR. GOSMAN: I attended Reference Committee #4 and I would like to say it was very well conducted. A lot of very good thought and discussion. I learned a lot. Nobody can tell yet what is going to come out of Reference Committee meetings. I do think most of the ideas presented there were accepted. Very few that were not accepted. There was a lot we need to learn about medical-legal matters.

CHAIRMAN: Thank you, Dr. Gosman. We will now hear from Dr. Kerr on Reference Committee #3.

DR. KERR: The major thing I think that came out of Reference Committee #3 and one which we should give considerable thought to is related to student loans. You will recall the other day when we had our first meeting we discussed the matter of the Student Minority Medical Association whom we referred to a loan committee. I did not realize that the loans we do have available are available at only about 1% less than you could obtain a commercial loan. I recognize there is some backing by ISMA of these loans. The medical students who were there and made comments pointed out it was almost impossible to really make connections to get a loan. The Dean was asked how many of the students were in debt and by how much. He stated they were almost all in debt and by figures averaging about $15,000 by the time they get through school. I think we need to take a very good hard look at our present position and see if we cannot make these loans easier to obtain and much less expensive.

DR. DUKES: I disagree with you. We give loans every month and have not turned down that many students.

DR. STEEN: I was on the Student Loan Committee and I think a lot of this has to do with the reasons for which they want the loan. We did turn down a student about a year ago who came in. He was only in his Junior year and he was already in debt for $15,000. He wanted the loan without getting a co-signature on the loan. He refused to ask his father. He refused to have his wife sign the loan and of course we said "no". In checking further, he wanted to buy a car. We had one who wanted to borrow $1500 to enhance his social activities since he had studied so hard for so many years. He got the loan. The point is, it is not all that difficult.

DR. SCAMAHORN: On receiving the letter from the minority group I took it upon myself to call the I.U. Foundation and obtained considerable information. Also recently I had the students in my home and there was one Ferrari; two Jaguars and my car was older than most of the cars parked there.

CHAIRMAN: If there is no further discussion we will move on to Reference Committee #5.

DR. CLARK: I think most of the things before the Reference Committee were very satisfactory as far as the Board is concerned. One great thing I was interested in, of course was the Orientation Program.

CHAIRMAN: Thank you, Dr. Clark. We will now move to Reference Committee #4. Dr. Ingram.

DR. INGRAM: I attended Reference Committee #4 along with Dr. Gosman and I believe there are a couple of things that should be mentioned. One was the peer review and the other was the Emergency Medical Service Uniform Ambulance Code. There was a lot of static from those testifying about these programs and in general I think they were in favor of uniform ambulance standards but the physicians in small towns, like me, were afraid that all of a sudden they would be without an ambulance to carry their patients. I think it will be reported out probably as written, maybe with some modifications to spell that out. As the resolution was written, it was just support for the bill that is already written and in the hands of the Commission on Legislation but there was considerable discussion by those who were worried about the outcome if this bill should be adopted. The same thing on the supporting resolution on the Hoosier Teen Health Happening. Everyone was generally in favor of it. I do not think that was any problem. I think it will be passed probably as written. There were some good ideas mentioned. One which had not occurred to me and that was the suggestion that because of transportation and school rules that they could not take their students on a trip and stay overnight. It was suggested that we make use of the I.U.-Purdue closed circuit TV, and putting it in a central location such as Indianapolis and transmit it to the students so they could be housed at home and attend at a regional campus. It sounded good to me and probably would cut the cost of the program.

CHAIRMAN: Thank you, Dr. Ingram. We will now move on to Dr. McIntosh. Reference Committee #1.

DR. McINTOSH: The discussions in this Reference Committee were very frank. I think they panned the Board a little about the action of the '67 House of Delegates which directed the Board of Trustees to review the Grievance Committee rules and I guess as of this date nothing has been done.

CHAIRMAN: Thank you, Dr. McIntosh.

DR. WILHELMUS: I would like to have a meeting of my committee on fiscal matters immediately following the conclusion of this session.

CHAIRMAN: If there is no further business we will adjourn to meet again at 7:30 A.M., Thursday morning, October 15.

BOARD OF TRUSTEES

October 15, 1970

The Board of Trustees met at 7:30 a.m. Thursday, October 15, in Randall's Inn, South Bend.

Roll call showed the following:

District	Trustee	
1	G.M. Wilhelmus	Present
2	Joe Dukes	Present
3	Donald M. Kerr	Present
3	Eli Goodman (Elect)	Present
4	Robert Reid	Present
5	Wilbert McIntosh	Present
6	Stephen Smith	Present
7	James H. Gosman	Present
7	Dwight W. Schuster	Present
8	Richard Ingram	Present
9	Peter R. Petrich	Present
9	William Sholty (Elect)	Present
10	Vincent J. Santare	Present
11	Lowell J. Hillis	Present
12	William R. Clark	Present
13	Otis R. Bowen	Present

District	Alternate Trustee	
1	Eugene Austin	Absent
1	Raymond Newnum (Elect)	Absent
2	Betty Dukes	Absent
3	E. L. Wallace	Absent
4	Jack Shields	Present
5	Cleon Schauwecker	Absent
6	Paul M. Inlow	Present
7	John O. Butler	Present
7	Joseph Kerlin	Absent
8	Paul Sparks	Absent
8	Robert Williams	Present
9	Lindley Wagner	Present
10	Thomas Tyrrell	Present
11	James Harshman	Present
12	Frederic Sehoen	Present
13	G. Beach Gattman	Present

Officers:

Lowell H. Steen, Hammond, President Present

Malcolm O. Seamahorn, Pittsboro, President-elect Present

Lester H. Hoyt, Indianapolis, Treasurer Present

Hugh K. Thatcher, Indianapolis, Assistant Treasurer, Present

Journal:

Frank B. Ramsey, Indianapolis, Editor, Present

Executive Committee:

Donald M. Kerr, Bedford, Chairman Present

Burton E. Kintner, Elkhart, Member Present

Delegates to the AMA

Don E. Wood	Absent
Eugene Senseny	Present
Frank Green	Present
John Farquhar	Absent
Jack Shields	Present

Alternate Delegates to the AMA

James Harshman	Present
Eugene Rifner	Absent
K. O. Neumann	Present
P. J. V. Corcoran	Present
Thomas Tyrrell	Present

Guests:

Jerry W. McRoberts, M.D., president, State Medical Society of Wisconsin; John Harter, M.D., president elect of Kentucky Medical Association, David Reynolds of Wisconsin; Donald Taylor of Iowa Medical Society, Tim Norbeek, AMA; and Mrs. Carole Rust.

Staff:

Howard Grindstaff and James A. Waggener

CHAIRMAN: The first item of business will be the report from the Committee on Fiscal Matters, Dr. Wilhelmus.

DR. WILHELMUS: Report from Finance and Economics Committee - Re: Proposal for computer usage at ISMA presented by Mr. Weiss, Data Controls, Inc.

Services: Two basic services are available: (1) A computerized membership system; (2) A computerized accounting system.

Details are listed on the attached sheets. The State Medical Associations of Illinois and Iowa and the American College of Ob-Gyn are now using this system. Michigan, Minnesota and Kentucky are considering it.

Advantages: Both systems would offer greatly improved efficiency. In addition:

(1) The time of three regular staff members would be released for the one month normally devoted to dues billing.

(2) It would no longer be necessary to employ additional help during the annual billing, a saving of approximately $1,000.

(3) The accounting system would release the time of a full-time bookkeeper.

(4) There would be complete monthly financial statements.

(5) The membership system would make available to county societies information not otherwise readily obtainable.

(6) The greater flow of information would tend to draw county societies and ISMA closer together.

(7) IMPAC would be supplied with an accurate list of contributors and non-contributors, with addressed labels for a second request to be sent only to the latter. (In Illinois this system increased collections by 15%.)

(8) Pre-printed labels for District mailings would be available to Trustees.

(9) Pre-printed address labels would be supplied for use on the ISMA *Journal* and the Newsletter.

(10) For a nominal fee, ISMA could supply specialty groups with rosters and/or mailing labels.

(11) Current information on all members would be available to ISMA, each district and all county societies.

Costs: Membership billing per year $6,000
Accounting system per year 1,800
Total annual cost $7,800

There is a one-time cost of $3,000 for initial conversion to the new system.

Recommendation:The Committee urges that the Board of Trustees vote in favor of purchasing both the computerized membership system and computerized account system.

Gilbert Wilhelmus, M.D., *chairman*
Otis Bowen, M.D.
Lowell Hillis, M.D.
Lester Hoyt, M.D.

I would move that we accept this report and adopt the proposal for computerized billing and accounting. Seconded by many.

DR. SMITH: **I would move to table this matter.**

CHAIRMAN: **All in favor? Opposed? The motion dies.**

The matter was then discussed by Dr. Schuster, Dr. Shields, Dr. Thatcher and Dr. Hillis.

DR. HILLIS: **I move the question.**

CHAIRMAN: **The question has been called for. All in favor of adopting the Report on Fiscal Matters say "aye"; opposed same. The motion was carried.**

DR. STEEN: I would like to introduce some of the guests we have with us this morning: Dr. John Harter, president-elect of Kentucky Medical Association; Dr. Jerry McRoberts, president, State Medical Society of Wisconsin; Mr. David Reynolds, director of scientific service, State Medical Society of Wisconsin; Mr. Donald Taylor, executive vice president, Iowa Medical Society; and Tim Norbeck, field representative, AMA.

CHAIRMAN: Thank you and we are glad to have you with us this morning. We will now move on to reports of Reference Committees. #1, Dr. McIntosh, anything additional to report at this time?

DR. McINTOSH: Nothing to report.

CHAIRMAN: Reference Committee 2, Dr. Dukes.

DR. DUKES: I am sure they have approved the president and president-elect reports and the Board reports. Board Report D, there was considerable discussion which ended up with the Reference Committee attempting to define peer review. Report H, college health forms, recommended further study of this matter. Report I - no problem. Report J - no problem.

Dr. Hoyt further discussed Reference Committee #2's report concerning the change from Robert's Rules to Sturgis Parliamentary Procedure and also the portion of the report dealing with legislation in malpractice cases.

The matter was discussed by Dr. Steen concerning the changing of the wording and Dr. Schuster was appointed to recommend an amendment to the report from the floor of the House.

Further discussion was had regarding the president's report and recommendations and review of other resolutions as contained in Reference Committee reports.

Dr. Petrich expressed his appreciation and thanks to the Board for being permitted to serve as chairman during the past year.

Dr. Kerr also expressed his thanks to the Board and the enjoyment he had had in being a member of the Board as he was retiring at this meeting.

CHAIRMAN: There being no further business, we will adjourn and I will remind you that there will be an organizational meeting of the new Board immediately following the close of the final meeting of the House of Delegates.

BOARD OF TRUSTEES

The organizational meeting of the Board was called to order by President Scamahorn following the final meeting of the House of Delegates.

Roll call showed the trustees all present except Dr. Gosman.

By secret ballot, Dr. Joe Dukes of Dugger was elected Chairman of the Board for the coming year.

By secret ballot, Dr. Donald Kerr and Dr. Wilbert McIntosh were elected to membership on the Executive Committee.

There being no further business the meeting was adjourned to meet again at 6:00 p.m., Saturday evening, November 14, at the Headquarters Building.

EXECUTIVE COMMITTEE

The Executive Committee met in the Headquarters office at 2:00 p.m., Saturday, November 14, 1970.

Roll call showed the following present: Donald M. Kerr, M.D., chairman; Malcolm O. Scamahorn, M.D., Peter R. Petrich, M.D., Joe Dukes, M.D., Lester H. Hoyt, M.D., Hugh K. Thatcher, M.D., Frank B. Ramsey, M.D., and James A. Waggener.

MINUTES OF THE MEETING held October 12 were approved on motion of Drs. Petrich and Scamahorn.

MEMBERSHIP REPORT was approved by consent.

Membership Report:

Membership report as of Oct. 31, 1970:

Number of members as of Dec. 31, 1969	4,482
1970 members as of Oct. 31, 1970:	
Full dues paying members	3,954
Residents and interns	91
Board remitted	57
Senior	352
Honorary	3
Military	39
Total 1970 members as of Oct. 31, 1970	4,496
Total 1969 members as of Oct. 31, 1969	4,477
Number of AMA members as of Dec. 31, 1969	4,330
1970 AMA members as of Oct. 31, 1970	4,322
Full dues paying	3,783
Exempt, but active	539
	4,322
Number who have paid state dues but not AMA dues as of October 31, 1970	174
Number who paid state dues but not AMA dues as of December 31, 1969	152

Treasurer's Office

The Treasurer's report was approved on motion of Drs. Hoyt and Petrich.

Organization Matters

SURVEY OF MEMBERSHIP - The survey of membership as ordered by the House of Delegates was approved to be sent with a covering letter and referred to the Board of Trustees on motion of Drs. Scamahorn and Petrich.

CHAMPUS FORM - A form to be used to explain benefits of the Champus program was reviewed and by consent was approved with a minor change of wording.

ISMA RESOLUTION TO AMA - A copy of the ISMA resolution sent to the AMA House of Delegates was reviewed for the information of the committee.

REPORT OF AMA-ERF - A financial report of the AMA-ERF was reviewed for the information of the committee.

CORRESPONDENCE BETWEEN DR. JOE DAVIS AND DR. STEEN - A copy of a letter addressed to Dr. Joe Davis from Dr. Steen was read for the information of the committee.

ACTION OF N.Y. MEDICAL SOCIETY - Action taken by the Medical Society of New York concerning AMA membership was reviewed for the information of the committee.

MINUTES OF RMP MEETING - Minutes of the October 7th meeting of the Indiana Regional Medical Program were reviewed and on motion of Dr. Petrich and taken by consent, the Executive Committee of the RMP is to be requested to meet with the Executive Committee of ISMA on December 16th.

LETTER FROM J. E. ARATA, M.D. - A letter from J. E. Arata, M.D., of Fort Wayne concerning relative value schedules was read for the information of the committee.

REPORT ON SURVEY-PRESCHOOL NUTRITION - A report concerning the recent survey in Marshall County on preschool children on the subject of nutrition and conducted by Ohio State University was reviewed for the information of the committee.

COMMUNICATION FROM DR. FARQUHAR - A comment of Dr. Farquhar concerning Emergency Planning was read for the information of the committee.

LETTER FROM STATE MEDICAL SOCIETY OF WISCONSIN - A letter from the State Medical Society of Wisconsin announcing the candidacy of Dr. Simenstad for Vice President of the AMA was reviewed for the information of the committee.

THE CITATION-MALPRACTICE - An article appearing in the Citation concerning the Supreme Court of New Jersey holding that a panel agreement was binding upon a patient was reviewed for the information of the committee.

BLUE CROSS RATE COMMITTEE GUIDES - The guides used by the Blue Cross Rate Committee in establishing hospital room rates were reviewed for the information of the committee.

LETTER FROM MR. FRANK R. BOOTH - A letter from Mr. Frank R. Booth, Business Manager of a Simpson Medical Group concerning the Blue Shield activities was reviewed for the information of the committee.

LETTER FROM STATE NURSES ASSOCIATION - A letter from the State Nurses Association requesting attendance at a meeting on November 18 was reviewed and by consent it was left to the President to determine who, if anyone, should attend.

MEDICAL DISCIPLINARY BOARD LAW - Submission to the 1971 General Assembly of a law to create a Disciplinary Board as approved by the House of Delegates was brought to the attention of the committee and on motion of Dr. Petrich and taken by consent, this is to be referred to the Board of Trustees and the Commission on Legislation.

LEGISLATIVE REPORTING SERVICE - Legislative Reporting Service offered by the Indiana State Chamber of Commerce was approved for distribution to members of the Commission on Legislation and the staff of the association and trustees who might request it, on motion of Drs. Scamahorn and Dukes.

CHAMBER OF COMMERCE MEMBERSHIP - Renewal of the membership in Indiana Chamber of Commerce was approved on motion of Drs. Petrich and Hoyt.

Blue Shield-Blue Cross Matters:

MINUTES BLUE CROSS EXECUTIVE COMMITTEE - The minutes of the Blue Cross Executive Committee held October 15 were reviewed for the information of the committee.

MINUTES BLUE SHIELD BOARD - The minutes of the Blue Shield Board meeting held October 25 were reviewed for the information of the committee.

LETTER FROM E. L. C. BROOMES, M.D. - A letter from Dr. E. L. C. Broomes of East Chicago, together with a reply from Blue Shield and a list of physicians affiliated with a credit service were reviewed for the information of the committee and by consent was referred to the Board of Trustees.

Convention Matters:

ATTENDANCE FIGURES - The attendance figures for the South Bend meeting were reviewed for the information of the committee and by consent referred to the Board of Trustees.

REPORT OF GOLF COMMITTEE - A report of the Golf Committee of the participation during the 1970 meeting in South Bend was reviewed for the information of the committee.

SPECIALTY GROUPS - The action of the House of Delegates requesting the specialty societies of the state to be responsible for the Scientific program in 1971 was reviewed for the information of the committee.

1972 ANNUAL MEETING - The 1972 meeting. Dr. Petrich moved and Dr. Scamahorn seconded that the Executive Committee recommend to the Board that the location of the '72 meeting be changed from French Lick to Indianapolis.

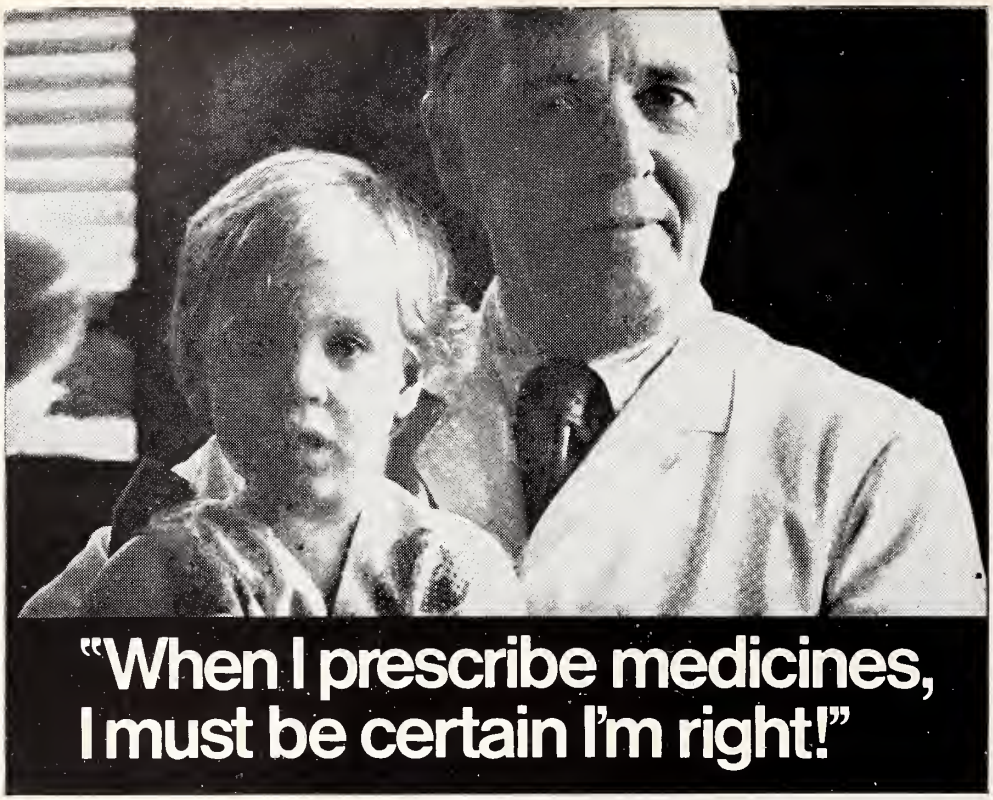
New Business:

WHITE HOUSE CONFERENCE ON AGING - The notice concerning the White House Conference on Aging to be held in 1971 was reviewed and on motion of Dr. Petrich and taken by consent, this matter was referred to the Commission on Aging, requesting that they do an immediate study and report back their findings to the Executive Committee.

Future Meetings:

On motion of Drs. Scamahorn and Petrich, the executive secretary is authorized to attend a Joint Conference on Medical Conventions in New York if he felt the program content was worthwhile.

There being no further business the committee adjourned and have requested that the Executive Committee of the Indiana Hospital Association meet with the ISMA Executive Committee at 10:00 a.m. on Wednesday, December 16; and the Executive Committee of the Indiana Regional Medical Program be invited to come in at 1:30 p.m. the same date; with the regular executive committee meeting following.



"When I prescribe medicines, I must be certain I'm right!"

A family doctor discusses the question of quality drugs.

In my practice of medicine, my first obligation is to my patients. When I prescribe a drug product, my purpose is to select a drug that will help the patient and do the job that I want it to do. I expect it to be of correct potency, accurate in dosage, with the precise amount of active ingredient, to be absorbed by the body at the proper time.

My feeling is that when I order a drug and I specify the precise product I want, I can control what my patients are going to get.

For their welfare and my own sense of security, I go with the drug products that experience has shown me work well. They may be brand name drugs . . . or they may be quality medicinals sold by their generic names. But they must be drugs that have proved they will do the job. I want to know their source and the reputation of the manufacturer. This freedom of choice should be mine, based on my knowledge and experience. With the potency of today's drugs, I don't know any safe ways to cut corners.

Another point of view . . .

Pharmaceutical Manufacturers Association, 1155 Fifteenth St., N.W., Washington, D.C. 20005



President and Mrs. Malcolm O. Scamahorn

1970 - The Convention Story



MEETINGS of the Board of Trustees were held at Randall's Inn.



ONE OF THE "musts" at a convention—the registration desk.



MRS. PETER R. PETRICH, Mrs. Lowell Steen and Mrs. Malcolm Scamahorn graced the head table at the Trustees Dinner—along with their busy husbands.



THE 1970 Trustees Dinner was a gala occasion.



MRS. DONALD M. KERR greeted Mrs. Patrick J. V. Corcoran and Mrs. Peter R. Petrich at the Trustees Dinner.



ANOTHER scene photographed at Monday night's Trustees Dinner.



THE ANNUAL Trustees Dinner was held at Randall's Inn on Monday night.



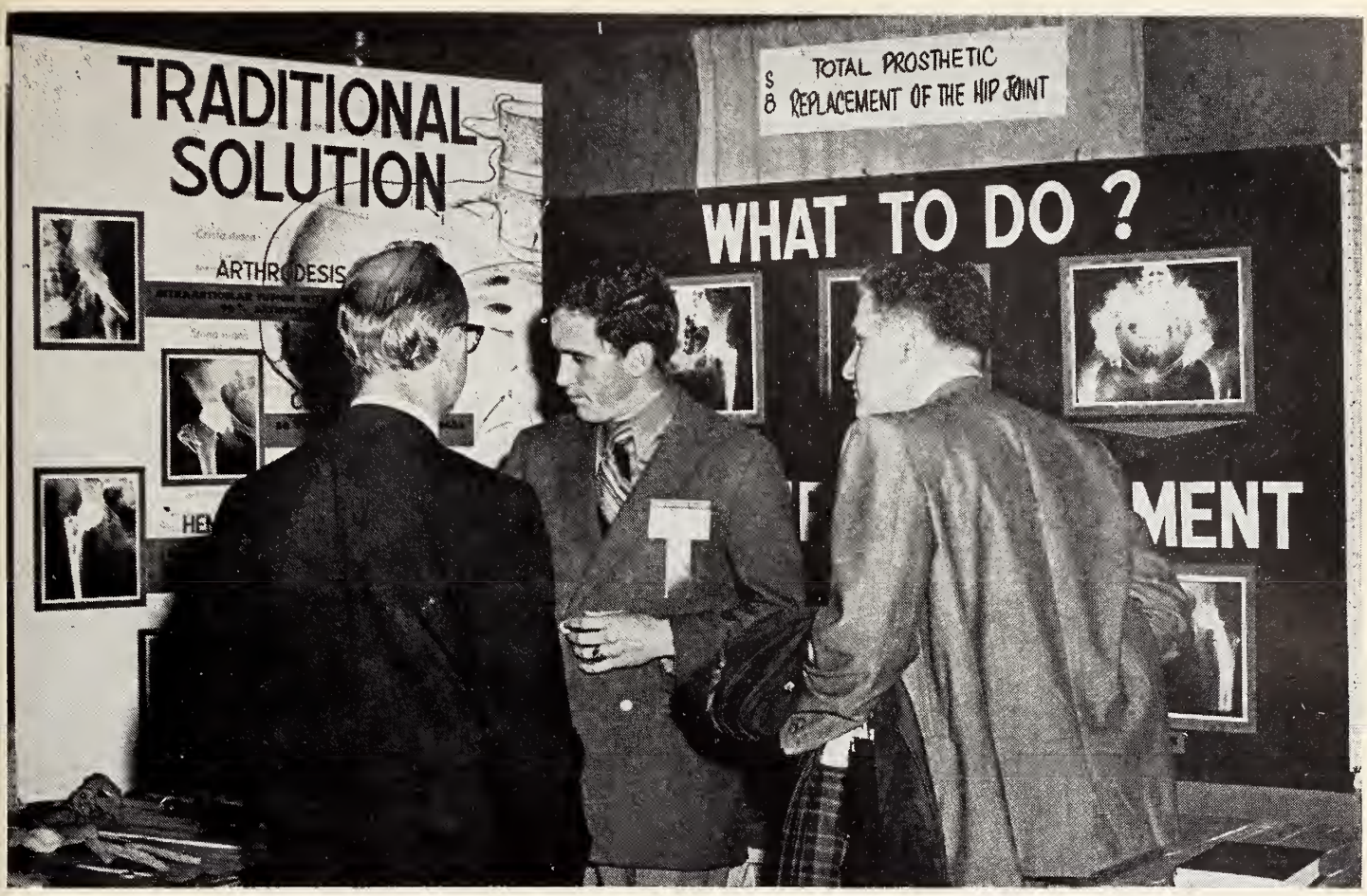
DR. J. ERNEST BREED, president of the Illinois State Medical Society (third from left) had a few pointers for Doctors William R. Clark, Fort Wayne, Malcolm Scamahorn and Lester H. Hoyt, Indianapolis, ISMA treasurer.



ONE OF THE technical exhibits the doctors found interesting.



A TECHNICAL exhibitor explains his products.



THE SCIENTIFIC exhibits drew many visitors.



INFORMAL conversations were the order of the day—every day.



THE BLUE SHIELD exhibit had some answers to questions brought by physicians.



MR. H. H. G. EASTCOTT, member of the Court of Examiners, Royal College of Surgeons of England (far right), had time for a chat between his platform appearances. Doctors Donald Wood, E. M. Beck and Austin Gardner, all of Indianapolis, are shown with him.



MISS CAROLINE YEAGER, secretary of the Indiana chapter, Student AMA, addressed the House of Delegates.



THERE WAS serious business transacted at the House of Delegates meetings.



THE CONCOURSE at the Notre Dame Athletic and Convention Center was an ideal place to meet and greet old friends.



THE WOMEN physicians met for lunch on Tuesday at the home of Dr. Agatha Wilhelm.



ANESTHESIOLOGISTS met for luncheon on Wednesday.



THE EDITORIAL BOARD of the Journal held its annual luncheon on Tuesday.



SECTION meetings on Wednesday began with luncheon.



REFERENCE COMMITTEES pondered long over their many assignments.



DR. RICHARD W. STANDER, Cincinnati, spoke at the Wednesday morning session.



MR. H. H. G. EASTCOTT, London, England, was one of the speakers.



DR. JOHN A. SPITTELL, Jr., Rochester, Minn., addressed a general meeting.



THE JOINT MEETING of the American College of Physicians and the Indiana Society of Internal Medicine was held at the Ramada Inn on Thursday.



DR. RICHARD L. FULTON, president of the Ohio State Medical Association, spoke to the House of Delegates.



DR. EDWARD SENAY, Chicago, addressed the Fireside Conference on Youth and Drugs Tuesday night.



JOHN NORRIS, Indianapolis, representative of the AFL-CIO, spoke on "Labor's Plan" at the ACP, ISIM meeting.



SOME OF THOSE in attendance at the ACP, ISIM meeting at the Ramada Inn.



DR. ELI GOLD, Cleveland (far right), spoke at the "Meet the Professor" session held Wednesday afternoon.



THE "Meet the Professor"' session had many participants.



THE FIRESIDE Conference on Youth and Drugs held at the Monogram Room was open to the public.



MANY TALENTS were on display at the Art and Hobby Show.



A WINNER in the Art and Hobby Show is tagged.



DR. STEEN, his wife, two daughters and their escorts enjoyed dancing at the Gaslight Party.





GAIETY prevailed at Wednesday's Gaslight Party at the Indiana Club.



THE PRESIDENT's Luncheon filled the Monogram room to overflowing.



ANOTHER view of the President's luncheon on Thursday.



DR. BARBARA BACKER, LaPorte, received the mental health award.



JERRY CHAPMAN accepted the public relations award on behalf of WFBM-TV, Indianapolis.



DR. EDWARD P. MININGER, Elkhart, accepted first place award for the scientific exhibit of the Hudson Medical Group, Inc.



DR. BARRY A. GOLDSMITH, Chicago, received the third place award for his scientific exhibit.



THE AWARD for second place went to the exhibit of Dr. Wilma F. Bergfeld, Cleveland, Ohio.



DR. DANIEL H. CANNON, New Albany, received the Community Service award.



OUTGOING President Steen received congratulations from his father and from Dr. Scamahorn when the latter presented him with the presidential plaque.



FOURTEEN members of the 50-Year Club were on hand for the President's Luncheon at which they were honored.



DONALD E. JOHNSON (third from right), Washington, D.C., Administrator of Veterans Affairs, spoke at the President's Luncheon.



DR. ROY V. MYERS (second from left), West Palm Beach, Fla., spoke for the 50-Year Club members who were introduced at the President's Luncheon.

Convention Election Results

Dr. Peter R. Petrich Named President-Elect

Dr. Peter R. Petrich, Attica, was elected president-elect of the Indiana State Medical Association at the closing session of the House of Delegates in South Bend on October 15. He succeeds Dr. Malcolm O. Scamahorn, Pittsboro, who will serve as president.

(An account of the careers and service to organized medicine on the part of Doctors Petrich and Scamahorn appeared in the November *Journal*).

Drs. Lester H. Hoyt and Hugh K. Thatcher, both of Indianapolis, were re-elected treasurer and assistant treasurer, respectively.

Elected chairman of the Board of Trustees was Dr. Joe Dukes, Dugger, while Dr. Donald M. Kerr of Bedford, was re-elected chairman of the Executive Committee.

Drs. Don E. Wood, Indianapolis, Eugene F. Senseny, Fort Wayne, and Frank H. Green, Rushville, were re-elected delegates to the American Medical Association, while the three alternates were also re-elected. They are: Drs. James A. Harshman, Kokomo, Eugene S. Rifner, Van Buren, and Kenneth O. Neumann, Lafayette. Their terms are two years.

New trustees chosen for three-year terms by their districts are Eli Goodman, Charlestown, District 3, and William M. Sholty, Lafayette, District 9.

Alternate trustees newly elected are: District 1, Raymond Newnum, Evansville, and, District 8, Paul D. Williams, Anderson.

New Section Officers

Officers who will head the various sections are as follows:

Section on Surgery: Chairman—Robert Rang, Washington; vice-chairman—Joe G. Jontz, Fort Wayne; secretary—Malcolm L. Wrege, Indianapolis.

Section on Internal Medicine: Chairman—Joel W. Salon, Fort Wayne; vice chairman—D. Edmund Storey, Indianapolis; secretary—Berj Antresian, Indianapolis.

Section on Ophthalmology and Otolaryngology: Chairman—George A. Clark, Indianapolis; vice chairman—Dana O. Troyer, Goshen; secretary—David L. Alvis, Indianapolis.

Section on Anesthesiology: Chairman—Everett Donnelly, South Bend; vice chairman—John H. Smith, Greenfield; secretary—David P. Lehman, Kokomo.

Section on General Practice: Chairman—Warren McClure, Kokomo; vice chairman—Robert Acher, Greenfield; secretary—James T. Anderson, Greenfield.

Section on Obstetrics and Gynecology: Chairman—Barton T. Smith, Marion; vice chairman—Jerome F. Doss, Kokomo; secretary—David E. Copher, Indianapolis.

Section on Public Health and Preventive Medicine: Chairman—Henry Nester, Indianapolis; vice chairman—James S. Robertson, Plymouth; secretary—Louis E. How, South Bend.

Section on Radiology: Chairman—Marvin N. Golper, Kokomo; vice chairman—Donald R. Taylor, Muncie; secretary—Dale B. Parshall, Elkhart.

Section on Nervous and Mental Disease: Chairman—Ivan Bennett, Indianapolis; vice chairman—Charles Eades, South Bend; secretary—Wesley A. Kissel, Indianapolis.

Section on Pathology and Forensic Medicine: Chairman—Harley P. Palmer, Franklin; vice chairman—Paul V. Evans, Indianapolis; secretary—Robert L. Costin, Indianapolis.

Section on Pediatrics: Chairman—George F. Parker, Indianapolis; vice chairman—Wendell E. Brown, Indianapolis; secretary—Donald L. Rogers, Indianapolis.

Section on Directors of Medical Education: Chairman—Franklin A. Bryan, Fort Wayne; vice chairman and secretary—Lindley Wagner, Lafayette.

Section on Cutaneous Medicine: Chairman—Jere D. Guin, Kokomo; vice chairman—Howard R. Gray, Indianapolis; secretary—Victor G. Hackney, Indianapolis.

Section on College Health Physicians: Chairman—John Miller, Bloomington; secretary—Wayne G. Pippenger, Muncie. ◄

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1970

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House of Delegates Proceedings

SOUTH BEND SESSION
October 13-15, 1970

The first meeting of the House of Delegates convened at 9 a.m., Tuesday, October 13, 1970, in the Monogram Room of the Athletic and Convocation Center, Notre Dame University, South Bend, Indiana, with Dr. Lowell H. Steen, president of the Indiana State Medical Association, presiding.

The second and final meeting of the House was convened at 2 p.m., Thursday, October 15, in the Monogram Room of the Athletic and Convocation Center, Notre Dame University, South Bend.

Invocation by Dr. Burton E. Kintner, Elkhart.

Report of the Credentials Committee

For the first meeting of the House of Delegates the Credentials Committee reported 89 delegates, 13 trustees and 8 past presidents in attendance. At the final session the report was 97 delegates, 12 trustees and 7 past presidents. The chair announced that inasmuch as 50 constitutes a quorum, there was a quorum present for both sessions of the House.

In Memoriam

Following is a list of members of the Indiana State Medical Association who were members of the House of Delegates or who served the Association in an official capacity and who have died since the 1969 annual session. The House stood in memory and tribute to the following:

CARL O. ALMQUIST, *Gary*
GORDON W. BATMAN, *Indianapolis*
EDGAR BRIDWELL, *Bedford*
JAMES C. BROWN, *Valparaiso*
HUGH W. EIKENBERRY, *Indianapolis*
JOHN K. FOLCK, *Princeton*
NAF F. GLADSTONE, *Fort Wayne*
ALBERT F. GREGG, *Connersville*
ELBIE V. HERENDEEN, *Rochester*
J. WILLIAM HERR, *Tell City*
JOHN B. HICKAM, *Indianapolis*
IRWIN S. HOSTETTER, *Muncie*
LOWELL G. HUNTER, *Lawrenceburg*
JOHN K. JACKSON, *Aurora*
ELMER G. KOEHLER, *Elkhart*
JAMES F. LEWIS, *Liberty*
LEE J. MARIS, *Attica*
NORMAN L. MEDCALF, *Lamar*
SAMUEL B. MONTGOMERY, *Cynthiana*
HARVEY L. MURDOCK, *Fort Wayne*
CECIL M. SENNETT, *Westville*
WILLIAM R. TROUTWINE, *Crown Point*
CHARLES L. VINEY, *Logansport*
WILLIAM C. WRIGHT, *Fort Wayne*

Approval of Minutes

The proceedings of the 120th annual meeting of the House of Delegates held in Indianapolis, Indiana and published in the December 1969 *Journal* of the Indiana State Medical Association were approved upon motion duly made, seconded and carried.

Introduction of Guests

The president introduced Dr. Richard L. Fulton, Columbus, Ohio, President of the Ohio State Medical Association; Rev. and Mrs. Joseph A. Steen, Delavan, Wis.; Dr. George R. Callender, Charleston, W. Va., President, West Virginia State Medical Association; Dr. J.W. McRoberts, Sheboygan, Wis., President, State Medical Society of Wisconsin and Dr. John S. Harter, Louisville, Ky., President-elect of Kentucky Medical Association.

Address of the President

HOUSE ACTION: Approved and heartily recommend the approval and acceptance of his address and hope for the implementation of his many suggestions.

Of the three learned professions, medicine, theology and law, we alone have enjoyed the confidence and respect of the public for many generations. There has always been a certain mysticism surrounding the work of the physician, and his presence is always a reminder of his influence over the life and death of each individual. Theologians, although dealing with these same areas, have been content, at least in the past, to obtain their rewards in the spiritual realm. Most people live a lifetime and rarely find the services of an attorney a necessity, and in those instances where they consult one, it is usually an elective matter. Therefore, I believe it is natural that much attention has been directed to our profession. Because humans are interested in their own well-being, politicians have been quick to seize upon this and use it for their own purposes. The public, in general, does not at times seem to have the ability to discern between fact and fiction, and the printed word to many individuals represents something more or less factual, if not sacred. Therefore, the politicians have had a tremendous advantage over us in their attempts to give our services to the public on their terms. We, therefore, are forced to wage a battle with our enemies to prevent further intrusions by our self-appointed partners—the government, labor, management, and the insurance industry. Sir Edmund Burke, the famous British parliamentarian and jurist, said in 1770, "When bad men combine, the good must associate, else they will fall one by one in unpitied sacrifice in a contemptible struggle."—I believe we must lay down new battle lines, or, by the end of this decade, we shall have only ourselves to thank for either a major triumph or undying tribulation.

We must reflect on some of the problems that we, as a profession, must solve in order to continue to enjoy the freedom to practice medicine as we have known it in the past—unhampered and unrestricted by federal regulation and with the public calling the tune to which we, by governmental fiat, will dance. Let us address ourselves to these problems and attempt to find solutions to them that are palatable to us. Foremost, let us mount an educational campaign to set the record straight, for our positive virtues outnumber our faults a thousand to one.

As we are now about three-fourths of the way through the first year of this new decade, I believe some insight into the future can be gained by a little hindsight into what has happened in the last fifty years. Prior to 1917, if a thousand people had gone to a physician, more than half of them would have died—many of them would have come out crippled—and the average hospital stay would have been longer than if they had stayed at home. There were not enough physicians then. Obviously, most sick people could not go to the more distinguished practitioners of that time. The medicine of that day consisted of salvarsan, quinine, morphine, digitalis and aspirin. There were a number of surgical procedures performed that were oftentimes harmful, and certainly the starvation diets, the purgings, and the dipping of patients in hot and cold water did little toward restoring them to health.

Since 1940, medicine has advanced more than it did in all the recorded history of mankind. From now until 1980, the knowledge in medicine will probably double again so that if we are alive then, there will be four or five times as much known in the health field as there was fifty years ago. In 1940 the health bill of this country was roughly four billion dollars. In 1965, just five years ago, it was forty billion, and today it is well over fifty billion, and I am sure that if you add all of the other aspects of the health bill like research, etc., it amounts to over sixty billion. This proves that both the laymen and the politicians thought the medical profession had something to offer. As society realized we had something to offer, it began to feel that it was important and that everybody should have it. At the White House conference on aging during the latter part of the Eisenhower administration, a group of people decided that health care should be a right for every person, along with the right to food and the right to shelter. Many of us disagree with this concept, although the belief is much in evidence today. The bills passed by Congress in the past few years, including Medicare, Medicaid, Regional Medical Program, and Comprehensive Health Planning are indications that the Government has tried to implement this concept, and, in a sense, has voted thirty million new potential patients into the mainstream of American medicine. The average physician works about sixty-five hours a week—many physicians work eighty hours a week. By adding thirty million people to the list of those who had health care before, these additional patients add at least fifteen hours to the doctor's back each week. Now, this is the crux of one of our problems.

We do need more physicians. But, in addition to needing more doctors, we need enough allied health personnel and we need to teach doctors how to use them effectively. Unless we do this rather promptly, I see no possibility, regardless of Government subsidy and of private insurance or even National Health Insurance, that will permit the patients to buy the type of care we are talking about. It has been suggested that there are multiple factors buffeting the health system which may tend to cause its complete breakdown. I doubt this. Yet, the problems of manpower and the use of additional technical facilities to promote health and to reduce the lag period of entry into the medical care system, as well as increasing the efficiency of each individual physician and institution, must come to fruition in the extremely near future. In our own state we are working on the Physician's Assistant Program. This is painfully slow due not only to the reluctance to accept these personnel by the profession, but due to a reluctance on the part of the educational institutions in this state to involve themselves in new and important programs. Little can actually be done until after the next session of the Legislature since certain legal delineations must be made as to whether these people will be licensed or registered, what responsibilities and obligations they have, and whether they will work solely in the physician's office or in the hospital while the physician is there, or whether they may work in the hospital under the direction of the physician in his absence. These are but a few of the problems besetting this one important element alone. Likewise, a single physician's assistant will not probably be adequate since we will probably need internist assistants, pediatric assistants, obstetrical assistants and other assistants ad infinitum. Furthermore, should these assistants be former Army and Navy Corpsmen or should they be R.N.'s or L.P.N.'s or graduates of a University School of Nursing or a community training school. We must make these decisions.

Effective use of the computer in history taking must be perfected in the very near future. The interpretation of an electrocardiogram by computer is here today, although currently the cost is of such magnitude that it is not widely applicable, either to the hospital situation or the individual physician's office. Effective systems of delivering out-patient care that will keep people out of the hospital must concern us very promptly, for we cannot continue to spend more and more dollars on brick and mortar. Developmental dollars must be poured into searching out new, more efficient techniques for the care of human beings, or a true crisis will genuinely be upon us. The mere provision of health care dollars or the enactment of a National Health Insurance program will not solve any of the problems about which we have talked today. Yet, this is the traditional solution of politicians to the problem of provision of care. As a profession, the medical profession must accept some of the responsibility for the very poor planning, and the hospital association must likewise accept responsibility for many ill-planned and inefficiently managed institutions. No real planning has existed for the crises that are upon us today, and from what I have seen of comprehensive health planning as it exists in Indiana today. I do not look for this planning to solve the very problems about which we are speaking. Too much time has been spent by self-appointed experts and by unsophisticated laymen in internecine struggle and in power politics for anything valid to be achieved in the next century-not to mention self-anointed bureaucrats who impose their monolithic approaches on the voluntary planners. There have been attempts at coordination of resources and facilities-yet, this is on a fragmentary basis and has yet to occur on any real and effective basis. I recognize that all planning takes time and that we could not jump from the horse and buggy to Apollo XIII in the matter of a few months, but good human minds and experimentation must supplant the endless flow of dollars and endless human verbosity in order for anything effectual to ultimately be achieved in the realm of manpower and in new techniques for increasing our efficiency.

The strain of providing additional health services through Medicaid financing to many millions who didn't have it before is another facet that is making our situation difficult. Inefficient management in public health programs such as one sees in Medicaid, the way the law was written, the way the state has chosen to interpret the laws, the way HEW has interpreted the laws, have all created new stresses and new problems for us. If I can draw a conclusion from the Medicaid fiasco, I do not believe any significant imagination will ever come from Washington—for Washington's sensitivity at-

tunes itself to those who seem to have the best answers and to those who have the ear of those in high places.

Dr. Sidney Garfield, the father of the Kaiser Foundation in California, has a clever classification for patients. He divides them into the well, the worried well, and the sick. Traditionally, our profession has handled the sick without difficulty and we continue to do so today. Our entire training and orientation is geared to the individual who is in need of our attention—the one for whom we can do something positive. As I see the problem today, it is the well and the worried well who will continue to multiply our problems in the future. We have always exercised preeminence in the field of preventive medicine, and we certainly continue to do this today—yet, the do-gooders and the social planners have seized this facet of our activities for their concern and for their platform. It is the obvious area in which we have not the technical facilities nor the manpower to provide each individual who would have an annual physical examination, or who would be counseled in dietary problems, or who would discuss with us the hazards of excess alcohol or smoking or many other health problems that beset this country today. Likewise, the worried well vex us since in most instances their needs are insatiable. Should National Health Insurance become a fact within the next week, this would add a burden to the already overworked physician so that we could not begin to scratch the surface of those who would clamor for our services. Alternative methods of service must be developed which we, as a profession, devise, operate and continue to control. A vast program of public education is a necessity, for what one wants differs vastly from what one needs. We can all recall parallels of this situation from our military experience, where care was a right subsidized by the Federal Government. We cannot afford any delay in presenting the facts to the public as we, the purveyors of medical care, know them to be. The care is not free and the demand for it will ultimately result in less of it for everyone. There are some sophisticated people in government who recognize the validity of these statements, but for political reasons scrupulously either deny or will not admit them publicly.

It is indeed too soon to predict whether we will solve the health manpower problems in the seventies, or any of our problems. We should certainly, at least, begin on them promptly.

There are twenty-five or thirty million people in this country who have no concept of health care whatsoever. When health care is available they don't know what services they should have, or more important, what they need. They don't know what good health care is and they often fall prey to cultists, or quackery, or spend good money on worthless nostrums. Much of what we need is education on how to live. It would appear to me that we need to concentrate on taking care of people on the simplest level possible with the least sophisticated hardware, and in the cheapest possible way. Yet to do this effectively, we must engage in a tremendous educational program. One repeatedly hears the time worn joke about getting a doctor to make a housecall. Yet, there is good and adequate reason for doctors not making housecalls today, but the public needs to be educated to this point of view in this highly productive, scientific and complex economic setup that now exists, rather for them to expect the traditional delivery of care as they knew it forty years ago.

Lastly, we do need to direct tremendous attention to prospective care. This, in effect, is preventive medicine- not the traditional preventive medicine with which we grew up. Many coronaries could be avoided if we could teach people how to eat properly and not to smoke so much. A large proportion of the vascular disturbances we see in this country are the direct result of an affluent economy in which our diet is laden with delicious fats such as butter, whipped cream, and rich pastry. The average patient who passes through my office for the first time is about 15 per cent overweight, and I personally carry on a busy educational program. But this needs to gain a wider audience than you or I alone can give it. With the billions of dollars of federal funds being devoted to health care, the voluntary agencies need to consider new ways of being of service to the public if they are to exist at all, and much thought should be given to their potential role in the health care scheme. Programs of rehabilitation from a variety of diseases are in need of infinitely greater study, and innovative programs making use of simple therapeutic tools that can be used in the home must be provided. We must think of the mulitude of people with chronic diseases who are in need of minimal care, surveillance, education and counselling—not expensively equipped hospitals and institutes. I have mentioned but a few of the many facets of the problems that we must solve in the seventies. I am sure we all have some idea about potential solutions to one or more of the problems that beset us. The ultimate solution rests with the ability to correlate and collate these suggestions and fit them into workable patterns that can achieve the goal we all seek—namely, the best possible health care for the maximum number of people.

Each practicing physician has an opportunity to influence a select audience—his own practice. Yet, as a profession, we must unite in this educational campaign and speak with one loud voice, repeating and repeating our message. We must regain confidence in our pronouncements and harken the words of Abraham Lincoln who said,—If you once forfeit the confidence of your fellow citizens, you can never regain their respect and esteem. It is true that you may fool all of the people some of the time. You can even fool some of the people all of the time, but you can't fool all of the people all of the time.—We don't want to fool anyone, least of all ourselves. We must harness our energy and adapt to the changes that are around the corner. But let these changes be the changes we elect rather than those that are forced upon us by our own indifference. It remains for us to elect whether we live in tribulation or bask in the triumph that our profession remains our own, and that we remain the captain of the team.

Printed Report of the President

HOUSE ACTION Approved as amended with the recommendation that these listed objectives be considered and implemented where possible by the Board of Trustees and/or appropriate commissions or committees.

Although the demands on the elected officers of this Association become greater with each passing year because of our involvement in more and more areas of concern, I have found this experience stimulating, enjoyable and rewarding. I wish to express my gratitude to the officers and members of the Lake County Medical Society for making this opportunity possible, and to every member of this House for this privilege accorded me. The year since last October 17 has passed quickly, and each day has been filled with new and exciting challenges. The time required to attempt to meet the essential commitments of this office is at times staggering. Yet, service to one's profession brings many rewards that more than compensate for the transient urgencies, harassments, and dislocations to one's practice. I cannot sufficiently express my gratitude to my patients, my associates, my employees, and, lastly, to my family

and my wife for the deluge of additional activities they have been forced to bear during this year. These comments are not intended to sound plaintive, for it has truly been enjoyable. I only wish it were possible for each physician in this state to, at some time, experience this involvement, for it is an education in what organized medicine really is.

Our accomplishments during the past year could never have become realities were it not for the loyalty, dedication and unswerving enthusiasm of our headquarters staff and of our chief executive officer, Mr. James A. Waggener, who, by himself and single-handedly is a veritable dynamo of activity.

I do not propose to outline to you the postive accomplishments of the past year, for they have been accomplished by the Board of Trustees, the delegates to the American Medical Association, this House of Delegates and the committees and commissions of this organization. Most of the highlights of our activities have been carefully delineated in the report of the Executive Secretary, and in the report of the Chairman of the Board of Trustees, and I urgently recommend careful study of these two reports to you, for they are factual, informative and enlightening. My most signal delight within the past year has been the response of the public and the press to the Hoosier Teen Health Happening. It is truly an example of what a voluntary association such as ours can do as an educational endeavor, but I can think of no event in the recent past which has been of such positive value insofar as public relations is concerned. We continue to reap the benefits of this event as the tapes and films are requested daily by high schools, churches and fraternal organizations throughout the length and breadth of this state as well as many requests from outside of Indiana. I know of no way to measure in dollars and cents the positive benefits of this program, but I feel certain that the cost per member is fully justified in spite of the tremendous effort expended, not only by the Board and your officers in staging this event, but the many, many hours of dedicated work on the part of the headquarters staff.

In the course of my activities as your president, I have had repeated necessity to study our Constitution and By-Laws. I have had an opportunity to observe the workings of the state medical associations of several of our neighboring states, and have gleaned from them certain operational techniques that I believe may be beneficial in promoting a more effective organization.

In studying Article V of the Constitution relating to the House of Delegates and the appropriate sections of the By-Laws, I find no point at which a statement is clearly made that all sessions of the House of Delegates shall be open to all members of good standing in this Association. This has always been an implied right of each member, and for purposes of clarity I RECOMMEND THAT THE COMMISSION ON CONSTITUTION AND BY-LAWS BE DIRECTED BY THIS HOUSE OF DELEGATES TO PREPARE APPROPRIATE WORDING TO AMEND ARTICLE V OF THE CONSTITUTION TO INDICATE THAT ALL SESSIONS OF THE HOUSE OF DELEGATES SHALL BE OPEN TO ALL MEMBERS IN GOOD STANDING OF THIS ASSOCIATION.

Under Article IX, Section VII of the Constitution, succession to the presidency in the event of death, resignation, removal or disability is provided for. However, I can foresee in this day of jet travel the potential of a president being absent for an extended period of time. I do believe the president-elect would, under those circumstances, carry on the duties of the president, although this is not specifically provided for. I THEREFORE RECOMMEND THAT THE COMMISSION ON CONSTITUTION AND BY-LAWS BE DIRECTED BY THIS HOUSE TO PREPARE AN APPROPRIATE AMENDMENT TO INSERT THE WORDS "TEMPORARY ABSENCE" WITH THE OTHER CONTINGENCIES THEREIN ENUMERATED THAT MIGHT EITHER PERMANENTLY OR TEMPORARILY REMOVE THE PRESIDENT FROM EXECUTING HIS DUTIES AS THE TITULAR HEAD OF THIS ORGANIZATION.

I have discussed this matter with the Board of Trustees and they have appointed a committee to study the matter. Personal and independent study leads me to make the following recommendation, since similar alterations have been made by other state medical associations and the American Medical Association. I THEREFORE RECOMMEND THAT THIS HOUSE DIRECT THE COMMISSION ON CONSTITUTION AND BY-LAWS TO PREPARE SUITABLE AMENDMENTS TO CHAPTER XXXII, SECTION I OF THE BY-LAWS, TO GOVERN THE DELIBERATIONS OF THIS ASSOCIATION IN ACCORDANCE WITH PARLIAMENTARY USAGE AS PRESCRIBED IN THE CURRENT EDITION OF STURGIS' STANDARD CODE OF PARLIAMENTARY PROCEDURE (BY ALICE STURGIS). This volume is better organized, more easily understood, and in many respects more contemporary than the Robert volume now prescribed by our By-Laws. Furthermore Sturgis has a section dealing with Reference Committees that is mentioned nowhere in Robert's.

The members of this House need not be reminded of the serious threat created by the continued escalation of malpractice insurance premiums and the mounting number of malpractice suits filed. The Commission on Medical Economics and Insurance has worked long and diligently to attempt to make adequate coverage for all our members a certainty at a substantial reduction in premium. The AMA is likewise devoting considerable energy in this direction on a cooperative basis. I believe it imperative that we also attempt other means to solve this ever-increasing problem. Some states, such as Alaska and California, have successfully revised the laws governing malpractice litigation in an attempt to make the process more equitable, more responsible to the public interest, and less emotional. I, THEREFORE, RECOMMEND THAT THE BOARD OF TRUSTEES, IN CONJUNCTION WITH THE COMMISSION ON LEGISLATION, BE DIRECTED BY THIS HOUSE TO RECOMMEND TO THE LEGISLATURE THE ADOPTION OF LEGISLATIVE CHANGES IN THE PUBLIC INTEREST WHICH WILL TEND TO SPREAD THE RISKS MORE EQUITABLY, DISCOURAGE FRIVOLOUS AND SPECULATIVE SUITS, GIVE INCREASED PROTECTION TO PHYSICIANS AND MEDICAL TEAMS ACTING IN GOOD FAITH, AND LIMIT AWARDS TO REASONABLE LEVELS. MOREOVER, I RECOMMEND THAT SOME ATTEMPT BE MADE TO DEAL WITH THE BOTHERSOME PRACTICE OF THE ATTORNEY'S CONTINGENCY FEE.

In the past decade there has been increased interest on the part of medical societies and individual physicians in pricing patterns in medical care and in the total cost of medical care. With the passage of the Medicare Act in 1965, further impetus to obtain factual information about physicians' activities in the economic arena has occurred. In Indiana many county societies are involved in various review programs dealing primarily with the unit cost of the delivery of service. Your State Medical Association has for a number of years amassed information through its administration of the CHAMPUS Program. In the past year the Commission on Medical Economics and Insurance has devoted considerable time and effort to the adjudication of economic

questions relating to this latter program. The several specialty societies have, through the years, attempted to collect data about the costs of procedures peculiar to the several specialties. We have, and I hope will, for the foreseeable future continue to remain an indemnity state. The autonomy and independence of each physician as a free agent should not be altered by third party involvement, be it government, private insurance or the Blues. However, we now find ourselves in the unique position of needing some yardstick by which the relativity of a procedure done by one physician can be related to that done by a man in a different field of activity. Many county societies have relied heavily upon the California Relative Value Schedule. Other counties use both the California Relative Value Schedule and a hodgepodge of specialty society relative value schedules. California, for reasons of its own, has long been the leader in establishing relative values for all procedures done by all physicians. IT MUST BE EMPHASIZED THAT THIS IS NOT A FEE SCHEDULE! IT IS A COMPILATION BY PHYSICIANS OF THE RELATIVE RELATIONSHIP OF THE SIMPLEST PROCEDURE DONE BY ANY INDIVIDUAL—I.E., THE ROUTINE OFFICE VISIT, TO ALL OTHER PROCEDURES. This in no way sets the fees of any individual, but does provide a yardstick by which one can judge what value a procedure has in relation to all other procedures. We have experienced some difficulties in a number of sectors in that nothing specific has been worked out for Indiana, per se.

Within the past year, additional activity has been devoted to improve not only the liaison but the communication with the many specialty societies. Your Board of Trustees has invited the specialty societies to utilize our facilities on a cost-plus basis in the hope that the fragmentation within the profession might be lessened. The Indiana Society of Internal Medicine has now contracted with your Association to perform certain of their clerical, billing and mailing functions, and their records now repose in the headquarters of the Association. It is hopeful that additional specialty societies will follow the lead of this progressive organization in the near future. However, the keeping of records and the assistance by staff and office personnel does not really solve the critical problem of lessening the ever increasing number of meetings. It does not encourage dialogue between members of various specialty societies with State Medical committees, commissions and officers. It does not permit the ultimate in unified action by the profession. IN THE INTERESTS OF BETTER COMMUNICATION BETWEEN THE INDIANA STATE MEDICAL ASSOCIATION AND THE SEVERAL SPECIALTY SOCIETIES, I RECOMMEND THAT A COMMISSION ON MEDICAL SPECIALTIES BE ESTABBLISHED, BY AMENDING THE BYLAWS BY ADDING A NEW CHAPTER TO BE KNOWN AS "CHAPTER XXIX. THE COMMISSION ON SPECIALTY MEDICINE" THE BALANCE OF THE EXISTING CHAPTERS TO BE RENUMBERED ACCORDINGLY. THIS NEW COMMISSION WOULD BE THE LIAISON IN DEVELOPING OF SCIENTIFIC WORK, LEGISLATION AND ALL OTHER FIELDS OF ENDEAVOR. This commission may be structured in a number of ways. It could differ from the other commissions appointed by the president in that the presidents of the various specialty societies could constitute the commission. This has certain limitations, in that an individual would probably only serve for a period of one year. Nomination by the specialty societies with ultimate appointment by the president for terms similar to the membership of other commissions is an alternative means of accomplishing this goal. I am convinced that the establishment of such a commission could ultimately have many benefits for the Indiana State Medical Association as well as the specialty societies.

The Board of Trustees will present to this House of Delegates a proposed legislative suggestion establishing a Medical Disciplinary Board as recommended in my report to the House last year as president-elect. You will recall the House directed the Board of Trustees to prepare such legislation and submit it to the House for further study and action at this session. May I again strongly urge upon you the many values of the State Medical Association promoting legislation of this type. I do not believe sweeping changes such as this should be made hastily, or without due consideration, but I strongly urge that this law be discussed and studied and, when we have honed it to a degree of perfection that is satisfactory to this House, I urge our wholehearted support for the passage of such legislation. I believe such legislation would be of inestimable assistance to us in solving many problems that, at present, we are without the resources to deal with effectively.

Lastly, the Board of Trustees during the past year has approved the use of our field staff in assisting component county medical societies in planning and executing their meetings. Several county societies have taken advantage of this service, and I call to your attention that the service is available to county societies who are without full-time or part-time executive help. The use of our field staff in planning and making program arrangements and caring for technical details can relieve busy physicians of many tedious responsibilities. This assistance by the field staff is an additional way in which your State Medical Association can be of service to the component county societies and to the practicing physicians of this state. The staff is willing to carry out these functions and is well qualified to assist you in many ways. The effective use of the field personnel is the key to making for a bigger, better and stronger Indiana State Medical Association.

LOWELL H. STEEN, M.D.,
President

Remarks of President Steen

Any delegate may introduce a resolution from the floor, provided that where a resolution has been first submitted to the Committee on Rules and Order of Business together with a written statement setting forth the reasons why said resolution was not mailed to the Executive Secretary more than 45 days prior to the meeting of the House of Delegates and also setting forth in said written statement the reason why said resolution is of such an emergency nature that it cannot wait until the next meeting of the House, and that said Committee on Rules and Order of Business has approved said resolution for submission to the House, and that each delegate shall be furnished a copy before the next meeting of the House, then this subsection of the Bylaws may be suspended with respect to said resolution upon a two-thirds vote of the House of Delegates.

Committee on Rules and Order of Business is in session just outside the entrance to the Monogram Room.

APPOINTMENT OF REFERENCE COMMITTEES

In accordance with the Bylaws, I have appointed reference committees, and the names of the members of these committees are published in the Handbook.

These reference committees are to serve during this annual convention only and should not be confused with the commissions or standing committees of this Association.

To these reference committees will be referred all reports, resolutions, and measures presented to the House of Delegates at this session, except such matters as properly come before the Board, and the

recommendations of these committees shall be submitted at the final meeting of the House of Delegates at 2 p.m., Thursday, October 15, for acceptance in the original or modified form, or for rejection. The Thursday afternoon meeting will be held in the Monogram Room, Athletic and Convocation Center.

Each reference committee consists of five or six members, the first member named is chairman. Will commitee members please stand as their names are called?

REFERENCE COMMITTEE NO. 1

Robert P. Acher, Greensburg (Decatur), *Chairman*
Fred S. Carter, La Porte (La Porte)
Frank H. Green, Rushville (Rush)
Kenneth L. Olson, South Bend (St. Joseph)
Thomas A. Neathamer, Jeffersonville (Clark)
Warren N. McClure, Kokomo (Howard)

REFERENCE COMMITTEE NO. 2

Walfred A. Nelson, Gary (Lake), *Chairman*
Isaac E. Michael, Indianapolis (Marion)
Fred Smith, Tell City (Perry)
George W. Willison, Evansville (Vanderburgh)
Truman E. Caylor, Bluffton (Wells)
Charles H. Aust, Fort Wayne (Allen)

REFERENCE COMMITTEE NO. 3

John W. Beeler, Indianapolis (Marion), *Chairman*
Ross L. Egger, Daleville (Delaware-Blackford)
Dean L. Mattox, Howe (LaGrange)
Glen Ward Lee, Richmond (Wayne-Union)
Malcolm L. Wrege, Indianapolis (Marion)

REFERENCE COMMITTEE NO. 4

DeWayne L. Hull, Fort Wayne (Allen), *Chairman*
William A. Ringer, Williamsport (Fountain-Warren)
Charles D. Egnatz, Schererville (Lake)
Lloyd L. Hill, Peru (Miami)
Samuel E. Bechtold, South Bend (St. Joseph)
Thomas J. Conway, Terre Haute (Vigo)

REFERENCE COMMITTEE NO. 5

Donald R. Taylor, Muncie (Delaware-Blackford), *Chairman*
Thomas A. Elliott, Elkhart (Elkhart)
Loren H. Martin, Indianapolis (Marion)
Fred C. Poehler, La Fontaine (Wabash)
Louis F. Sandock, South Bend (St. Joseph)

TELLERS

T. Neal Petry, Delphi (Carroll)
Robert M. Brown, Marion (Grant)
John O. Butler, Indianapolis (Marion)
Thomas O. Middleton Bloomington (Owen-Monroe)
John J. Reed, Hobart (Lake)

Amendments to the Constitution

HOUSE ACTION: Adopted.

Be It Resolved that Article IV, of the Constitution be amended by adding a Section 3, which shall read as follows:

"Sec. 3.—Interns and Residents. Interns and Residents who hold membership in the Indiana State Medical Association shall have all the rights and privileges of this Association except the right to hold office and to vote."

Be It Further Resolved, that Article IV be further amended by renumbering the present Section 3 to Section 4; by renumbering the present Section 4 to Section 5; by renumbering the present Section 5 to Section 6; by renumbering the present Section 6 to Section 7 and renumbering the present Section 7 to Section 8.

Be It Further Resolved, that Article IV, the present Section 7 be renumbered Section 8 and amended to read as follows: "Sec. 8.—Rights and Privileges of Members—Active members, senior members and disabled members shall have the same rights and privileges except as follows:" (the balance of this Section to remain the same).

Be It Resolved, that Article XI, Sec. a. of the Constitution be amended to read as follows: "a. Membership dues to be collected may be collected by the Indiana State Medical Association or by the component county societies in connection with the dues for such component societies. The amount of dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates."

Presentation of Plaques

The president at this time presented on behalf of the American Medical Association plaques recognizing the humanitarian service of volunteer physicians in Viet Nam. Presentations were made to Drs. John Bender of Goshen and Galen Miller of Elkhart.

Address of President-Elect Malcolm O. Scamahorn

HOUSE ACTION: Approved.

I would like to read some of the specific purposes of our organization as set forth in the Association's Constitution and By-laws. These purposes are so everlastingly true. I read

"to extend medical knowledge and advance medical science;

"to elevate the standard of medical education

"to protect its members against imposition

"to enlighten and direct public opinion in regard to the great problems of medical care and public health

"so that the profession shall become more capable and honorable within itself and more useful to the public

"in the prevention and cure of disease

"in prolonging and adding comfort to life."

As our young contemporaries would say, "That's beautiful, beautiful!"

Friends in medicine, this is our challenge. Let us together share our philosophies, our own thoughts and our prejudices and, upon reaching a majority decision, agree to bury our differences for the benefit of our membership, our Association and its service to the public.

Health care is changing rapidly these days, despite our critics' claim that we still have a cottage industry. A change, obviously present, is that at our elbows we have persons who do not render health care. They are called by various names and titles but are social planners and representatives of third party payors. I think they are here to stay. As I learned in my early childhood, "He who pays the fiddler, calls the tune." Third party payments make up over 50% of health care costs today. Advocates of national health plans and "pushers" of socialized medicine are sounding off all over the land and, like all propagandists, they ignore significant facts, More and more physicians will be needed to implement these plans while they ignore that already there is a shortage of doctors. This shortage will continue despite increased medical student enrollment such as at Indiana University and the other proposed plans statewide. Our critics do not break down medical fees separate from drug costs, costs of supplies, hospitalization, but only talk about health costs. Any thoughtful person knows the large increase in cost has come from hospitalization costs. Americans today are spending a little less (0.3%) of their spendable income for health care than in 1965. Insurance is not a magical answer to cost and it will and does not lower costs; it only spreads the actual cost over an insured group.

Our Association must seek out, recognize and train medical leaders and spokesmen on a continuous plan. These persons need not only be the elected members but devoted physicians who will take the time to be effective spokesmen for medicine. The speakers' bureau must be publicized more and the speakers trained,

for the public desires our opinion on medical matters. Leadership training programs must be available for those who wish to become more effective. The first such program will be available January 1971 for our state leaders, commission chairmen and other leaders. The District Society must be examined and studied in depth; its value, to science, to its members, its use by membership and possible alternative methods of district elections must be evaluated. More and more the Association must become active in medical economics and health services. We must obtain from our members information on fees, services and health care patterns on local and regional bases. Then this information can be used by our membership and by the Association to refute charges made by our critics. Communications between the membership, the county society and ISMA can and must be improved. It would be helpful if the officers of the component societies were elected in late spring, allowing the summer months to be used for program planning, then assume office in early fall, concurrent with change in ISMA officers. This would make for a stable, more effective officer body relating to each other and the State Association.

Medical student relationships are improving with our Association and rightly so. The student delegates from Indiana University School of Medicine are with us today. May I introduce Caroline Yeager and Bonnie Garrison. Later this month I will appear before the other IU students to explain their continued role in our House of Delegates and urge them to participate more in our Commissions as liaison. We do care about the student views. County societies could help the students and stimulate interest in their local area of practice by making and keeping contacts with all the medical students from their county. This should be throughout their four years of school and in their post M.D. training. At a minimum, an annual dinner get-together with the students and their wives or husbands and the husbands and wives of the local society. The Association also could set up a "Big Brother-Buddy" system for the student to relate to and know some active practicing physician. Preceptorships must be urged to be more widely used as an educational experience. Too, a faculty visitation to the practice of a local M.D. would aid greatly in bettering this relationship and improving the quality of education for the student.

Legislatively, we physicians are generally inept. We tend to be authoritarian, deal only with facts and become impatient if progress is slow. Politicians deal in what the public thinks are the facts, are compromising to obtain their desires. I urge that each of us go home, work, talk and support our favorite candidates. Money alone will not do the trick. The election can still be affected by your action from now on to the voting day. On the state level, we have five physicians running for the legislature. They are Doctors Bowen, Coleman, Eisler, Lampkin and Pierce. No other state has such representation from its doctors. This newly elected legislature will not only re-district the state but act on some seventeen pieces of medical practice matters. The field staff are to be commended as well as several county societies for financially and vocally supporting their legislative favorites. On the national legislative area, national health insurance, amendments to the Social Security Act and Medicare are being studied. Gentlemen and Friends of Medicine, it is clear-cut which senatorial candidate has been our friend. Support him and your other favorites, but work.

These are troubled times but let us work diligently and wisely for medicine. Let us work as emotionally mature persons. To do this, the late Dr. Menninger said, in part, one should

-have the ability to deal consistently with reality
-have the capacity to adapt to change
-have the capacity to find more satisfaction in giving than receiving
-have the capacity to love.

A film prepared by the AMA Public Relations Department was presented at this time.

Remarks of Mrs. Paul A. Clouse, President of the Woman's Auxiliary to the Indiana State Medical Association

HOUSE ACTION: Approved

Dr. Steen, Distinguished Guests and Members of the House of Delegates:

The forty second year of the Woman's Auxiliary to the ISMA came to a close following the April House of Delegates Meeting in Columbus, Ind.

Under the dynamic leadership of Mrs. Kenneth Schneider, our 1969-1970 president, the state auxiliary has continued to move ever onward, never faltering in the process of carrying out our aims and goals. Indiana's report given by Mrs. Schneider in June at the AMA meeting in Chicago was proof of our accomplishments.

Our membership for the year totaled 2,754 members. We had a drop of 100 in membership this year, enough to make us lose one delegate vote at the National meeting. This was mainly due to the loss of one Auxiliary and we fervently hope to regain it soon. We, however, have added one newly organized group so this will help our membership next year.

A contribution of $17,722 was made to AMA-ERF this year and $10,000 was made available for loans and scholarships. Twelve and one-half tons of supplies were sent to World Medical Relief, and 17 Indiana doctors have gone to India and five to European countries.

Our Auxiliaries and individual members have been involved in child guidance clinics and are directors on local mental health boards. Randolph County, one of our smaller auxiliaries, purchased an old school bus to use for transporting mental patients on outings and volunteers to their hospitals. In addition, they raised $2,500 toward building a prayer chapel at a state hospital.

Our auxiliary members are also active in family planning clinics, measles vaccine clinics, well child and baby clinics and blood banks.

An auxiliary member is now on the professional advisory board of Indiana Health Careers, Inc., a professional group with which we work closely.

We have a very active WA-SAMA group and they are in the process of organizing the wives of interns and residents. We assist them personally and financially.

The Handbook, which is a manual for all state officers, was revised this year. I might add here that I have had requests from other state presidents for a copy to pattern one for their own auxiliaries.

Our state budget provides that each county legislative chairman shall receive "Legislative Round-Up." This report plus the efforts of our State Legislative Chairman, has kept us all informed on the current political issues.

The *Hoosier Doctor's Wife*, our own publication, is published and sent out four times a year to every paid auxiliary member. Jean Green, our editor, was recently appointed to the newly created editorial board of *MD's Wife* to advise and help the editor of this publication; she will also remain on the staff as an active writer. The *MD'S Wife* is the official national publication for the Auxiliary member.

In April, when the Indiana State Medical Association sponsored the "Hoosier Teen Health Happening" in Indianapolis, the Auxiliaries assisted in contacting the high schools personally. They also supplied transportation, chaperones and financial assistance. There were 215 schools

repesented with a total of 3000 students in attendance. We are most eager to help in any way we can again this coming spring.

September 23rd saw a combined Workshop for the state and county officers and chairmen and any interested members. We had a very successful meeting and were honored to have Dr. Otis Bowen as our luncheon speaker.

Again this year there is an overlap of dates for this meeting and the National Conference for Presidents and Presidents-Elect of all 50 states in Chicago. I attended two days and my successor, Lelia Chernish will stay for the end of the meeting. Also starting this Thursday in Chicago is the North Central Regional Workshop for presidents, presidents-elect and four key state chairmen, being different each year. We gain confidence in our job and much new knowledge at these meetings, new material to present to our county auxiliaries as we travel around the state.

It is a real pleasure to be able to be the President of WA-ISMA and I deem it quite an honor—one main reason is the warm welcome I receive everywhere I go —and the many wonderful friends I have made. We are most grateful for the cooperation and guidance we receive from our Advisory Council and from the ISMA staff.

We sincerely thank you all for your continued interest in the Woman's Auxiliary.

Remarks of Miss Caroline Yeager, Secretary of the Indiana Chapter, Student American Medical Association

HOUSE ACTION: Approved and recommended that ISMA enter into the MECO Program.

Bonnie Garrison and I wish to thank you for allowing us to attend the convention and to observe the deliberations of the House of Delegates. I anticipate that we will learn much from our experiences this week. I would like to talk today about the purposes and programs of the Student American Medical Association.

SAMA is an organization of three goals.

The first goal is to offer service to our membership. To achieve this goal, we have offered instruments, lab coats and clinical jackets to students at reduced prices. We have taken the profit required by nonvoluntary groups and returned these profits to the students in the form of substantial discounts.

SAMA runs a bookstore to buy and sell used textbooks, a service not otherwise available on campus.

Through the national offices, we are able to include in the regular SAMA dues membership in the graduate student buying service. This service allows students to buy cars, furniture, and appliances at near dealer's cost, plus savings on travel and hotel accommodations.

SAMA publishes a national magazine, THE NEW PHYSICIAN, which brings our members articles on clinical, social, and legal aspects of their profession every month. We have published the only campus newsletter for medical students in the past. However, due to lack of funding, plans for future issues are tentative at this time.

The SAMA-Associated Southside Community Health Clinic runs a coffee shop in the main classroom building, dispensing coffee to help students through the regular morning lecture marathons.

SAMA's second goal is to offer opportunities for students to give service to the community. The SAMA-Sponsored Southside Community Health Clinic is now in its second year of operation. It delivers inexpensive health care to an area of Indianapolis that was formerly without adequate or acceptable health care. The clinic is staffed by students, faculty and physicians from our area who donate their time to the clinic. Drugs are supplied by 15 drug companies. Students from dentistry, allied health, and social service also donate their time to this project.

On a national level SAMA has organized the Appalachian Program in an attempt to deliver health care to indigent Americans living in the Appalachian area. Students volunteer their time to assist physicians in this area where health care was heretofore virtually unknown.

Another national volunteer program of SAMA is the SAMA Indian Project. The program is designed to upgrade the quality of health care delivery to a minority group too long forgotten.

The third goal of SAMA is to further the education of students and to promote social contact between students. To further the student's education, we sponsor a satewide preceptorship program to allow students to visit physicians and observe the finer points of medical practice. Our national organization offers international exchange preceptorships to encourage education and friendship on a worldwide basis.

We hold monthly chapter meetings, open to members, guests and friends, that range from didactic presentations to discussions of social problems to—frankly—some pretty mellow beer blasts. Our next meeting will be on October 20th and will feature Dr. Donald E. Wood who will discuss medical legislation. Our officers are members of the Student Council and participate in discussions and decisions that affect student life. Our auxiliary, WA-SAMA, sponsors dances, low rental furniture and meetings of interest to students' wives.

This is what SAMA is today. What will it be in the future? SAMA has never been a static organization. Our policy is dictated by the interests of the student membership. If a student or group of students express an interest in a program of service to students or the community or in a topic for a meeting, we try to let him develop his ideas and give him what support we can.

Consequently, the relative strength of our various programs varies from year to year. The worthwhile pograms survive, the others don't.

One project currently in view is MECO, Medical Education and Community Orientation. This program was established in 1968 in Illinois. It is now operating in 15 states. The program provides an opportunity for medical students to work in a hospital, usually for a 10-week period, under the leadership of a physician, contributing to patient care. In this way the student becomes interested in and attuned to medicine as practiced in small town hospitals. This experience could hopefully influence the student's choice of practice later to a locale within the state which educated him and direly needs the new physicians who leave it every year. Currently, discussions of this program, as it may apply to Indiana, are underway. I understand from Doctor Scamahorn it was approved yesterday by the Board of Trustees.

SAMA feels this is a worthwhile program, one that deserves serious attention.

In conclusion, we feel that an open minded approach to the needs of students is the best one. In the past year, the interest in SAMA has been less than in previous years, but I have faith in SAMA — that if we are open and honest in our response to the students' needs — they in turn will respond to us with service, with imagination, and with support. Thank you.

Report of Chairman of the Blue Shield Board of Directors

HOUSE ACTION: Reference Committee recommends the report be filed.

DR. BLACK: My report to you is printed and available in your packet. It is also

available to all physicians in the state and other interested individuals. I do want to tell you this. Blue Shield's growth has been fantastic. Its performance has been excellent. Our problems are solvent. I am sure we can meet the problems and challenges of the seventies well. Thank you.

Election of Officers

OFFICERS: Dr. Malcolm O. Scamahorn of Pittsboro assumed the office of president and Dr. Peter R. Petrich of Attica, was elected president-elect.

Dr. Lester H. Hoyt, Indianapolis, was re-elected treasurer by acclamation.

Dr. Hugh K. Thatcher, Jr., Indianapolis, was re-elected assistant treasurer.

Elected chairman of the Board of Trustees was Dr. Joe Dukes, Dugger. Dr. Donald M. Kerr, Bedford, was re-elected chairman of the Executive Committee and Dr. Wilbert McIntosh, Riley, was elected a member of the Executive Committee.

ELECTION OF TRUSTEES: Two new trustees elected in 1970 were Dr. Eli Goodman, Charlestown, Third District and Dr. William M. Sholty, Lafayette, Ninth District. Drs. Stephen Smith, Knightstown, Sixth District, and William R. Clark, Fort Wayne, Twelfth District, were re-elected.

Newly-elected alternate trustees were Drs. Raymond L. Newnum, Evansville, First District; Paul M. Inlow, Shelbyville, Sixth District, and Robert D. Williams, Anderson, Eighth District. Drs. Jack E. Shields, Brownstown, Fourth District; Cleon M. Schauwecker, Greencastle, Fifth District, and G. Beach Gattman, Elkhart, Thirteenth District, were re-elected alternate trustees.

AMA DELEGATES AND ALTERNATE DELEGATES: The following were re-elected to a two-year term as delegate and alternate delegate to the American Medical Association, their terms to expire December 31, 1972:

Delegate, Dr. Don E. Wood, Indianapolis; alternate, Dr. James A. Harshman, Kokomo; Delegate, Dr. Eugene F. Senseny, Fort Wayne; alternate, Dr. Eugene S. Rifner, Van Buren; Delegate Frank H. Green, Rushville; alternate, Dr. Kenneth O. Neumann, Lafayette.

Reports of Officers

Executive Secretary

HOUSE ACTION: Approved.

The executive secretary considers it a privilege to make an annual report to the House of Delegates and to review some of the accomplishments of the association during the past year. This report, while not complete and in detail, we hope will give the membership some idea of the many activities which are carried on through your state association headquarters office.

Your headquarters is responsible for maintaining membership and dues records; conducting the official correspondence; notifying members of meetings; officers of their election; committee and commission members of their appointments and duties and preparing minutes of all official meetings of the association. All methods of communication are utilized to extend the influence and usefulness of the Indiana State Medical Association.

The following highlights some of the more important activities of the office of executive secretary and your headquarters staff.

Actions of the 1969 House of Delegates and Their Disposition

Resolutions:

69-2 Was circularized to all physicians through the publication of the proceedings of the 1969 House of Delegates.

69-3 This resolution intent was discussed by the Executive Committee on their visit to Congress in April of 1970. We understand there may be some remedial action as the result of the current study in certain changes in the Title XVIII and Title XIX programs.

69-4 Was referred to the Commission on Public Health and the commission report to this House contains their recommendations.

69-5 While there has been no specific effort made, the Indiana chapter of Internal Medicine has moved its office facilities into the headquarters building of the association.

69-6 Again nothing specific has been done with implementing this resolution but President Steen will ask the House of Delegates to authorize the creation of an organization of all specialty groups in the state of Indiana.

69-10 This resolution has been referred to the Commission on Legislation and there may be a report available following the September meeting of this commission.

69-11 Referred to the Commission on Public Health. They have made a recommendation to the Commission on Legislation for a change in the law governing TB testing.

69-12 Insured ambulatory diagnostic benefits. Referred to Board of Trustees. Board action was reported to 1970 House through "Board Report 70-A."

69-13 Physician Shortage. Referred to Board of Trustees. Board action was reported to 1970 House through "Board Report 70-E."

69-14 Medical Education. Referred to Board of Trustees. Board action was reported to 1970 House through "Board Report 70-B."

69-15 Delivery of Health Care. Referred to Board of Trustees. Board action was reported to 1970 House through "Board Report 70-E."

69-16 Health Manpower. Plus recommendation of Dr. Steen. Referred to Board of Trustees. Board action was reported to 1970 House through "Board Report 70-C."

69-18 Continuing Medical Education. Referred to Board of Trustees. Board action was reported to 1970 House through "Board Report 70-F."
Dr. Steen's request that county societies show evidence of their attempts to organize programs in continuing medical education—under study by the commission.
Dr. Steen's recommendation that Commission on Medical Education be instructed to develop a curriculum of the programs now available in Indiana and that the curriculum be kept current. Referred to Commission on Medical Education. No action other than announcements of programs offered through the medical school.

69-19 Peer Review. Referred to Board of Trustees. Board plans to take action on a final report at its meeting to be held September 12-13.

69-20 College Health Form. Referred to Board of Trustees. Board action was reported to 1970 House through "Board Report 70-H."

69-21 The resolution, as written, constitutes a change in the Bylaws which has been made under Chapter 3, Section 1, item "n."

69-22 SAMA representation in the House of Delegates. Referred to the Commission on Constitution and Bylaws. Reported to 1970 House through the report of the commission.

69-23 Was adopted by the House having the effect of increasing the dues $10.00 effective January 1, 1970.

69-24 Reporting on Financial Status. Report to 1970 House is made through "Board Report 70-J."

69-25 Resolution on Medical Board Procedures. Not adopted by the House but was referred to the Commission on Legislation. Report of the recommendation for the establishment of Medical Disciplinary Board constitutes action on this resolution, if approved by the Board at their meeting Sept. 12-13.

69-27 Review of Blue Cross-Blue Shield Certificates. Referred to Board of Trustees. Board action—A special Board Committee has been appointed and the Board will probably review their findings at the September meeting of the Board. If the report is ready, it will be labeled "Board Report 70-D."

69-28 Dissemination of Information. Board of Trustees' actions have been done by the headquarters office.

69-29 Responsibilities of Trustees. See reports of trustees.

69-32 This was referred to the legal counsel of the association. He has the matter under consideration and is in the process of preparing a proposed bill which will require compulsory arbitration for the 1971 General Assembly action, if approved by the Board of Trustees.

69-33 As written constitutes a change in the Bylaws and, when adopted, the change was appropriately made.

69-34 This resolution is referred to the Commission on Legislation and a bill will be introduced in the 1971 session.

69-35 District Trustee Representation. Action reported to 1970 House by Commission on Constitution and Bylaws.

69-36 This resolution has been handled by the Board of Trustees and by the Commission on Governmental Medical Services and has resulted in the creation of a Medical Insurance Review Committee comprised of four members of the Blue Shield Board; two members of the Association's Commission on Governmental Medical Services and two members of the Commission on Medical Economics and Insurance. This committee met for organizational purposes on August 16th and there will soon be an announcement made to all county societies as well as commercial insurance carriers of the creation of this committee.

The basic work has been done in contact with the State Department of Public Welfare and the Blue Shield Plan, administrator for Title XVIII and Title XIX. Complaints which have been received from physicians have been transmitted by these committees to Blue Shield and to the State Department of Welfare and the association has been provided with reports as to the findings on delay for payment.

69-37 Teacher Certification for Health Education. Referred to Board of Trustee. Board action—Referred to Commission on Public Health.

President-elect Steen's recommendation. Study of Medical Disciplinary Board. Copy of law proposed is presented to the 1970 House for action, if approved by the Board.

Physician on Indiana State Highway Commission. Referred to Commission on Legislation. No action as yet.

Hoosier Teen Health Happening. Held April 23-24, 1970, with over 3,000 high school pupils in attendance.

Membership

The report of membership is contained in detail in report of the Executive Committee, however we might point out that growth, while it still continues, does reflect a slower pace from the period of July, 1969, to July of 1970.

Total Members	Dec. 31, 1969	Dec. 31,1968
ISMA	4482	4440
AMA	4330	4286

July 31, 1969	July 31, 1970
4450	4455 + 5
4301	4291 − 10

By Districts as of July 31, 1970

District	ISMA + Gain − Loss	AMA + Gain − Loss
1	+6	+7
2	−3	0
3	+2	+1
4	−1	−1
5	+4	+4
6	+10	+9
7	−7	−8
8	+3	+1
9	−6	−8
10	0	−3
11	+3	0
12	+2	−4
13	−8	−8

The component county societies showing the most active operation as far as membership gain and loss are concerned for the period of July, 1969, to July, 1970, are as follows: Gain—Delaware-Blackford and Bartholomew-Brown both tied, showing a gain of 5; Vanderburgh County, 6; Allen County, 7. The largest loss in membership is shown by Marion County with a loss of 6.

Executive Committee

Your Executive Committee has met each month to transact the routine business of your association. The minutes of their meetings are published in *The Journal* for the information of the entire membership. A complete set of their actions has been given to the Reference Committees for their review. A capsulated report of the committee's actions will be found elsewhere in the reports to the House of Delegates.

Board of Trustees

The Board of Trustees has met eight times since the 1969 annual meeting and has two other meetings scheduled prior to the meeting of the 1970 House of Delegates. The next meeting of the Board will be held on September 12-13 and the other on October 12th.

In accordance with the action of the House of Delegates, an abbreviated, quickly read report to the trustees; county society officers; delegates and alternate delegates to ISMA; and delegates and alternate delegates to the American Medical Association have been distributed within two weeks following each meeting of the Board. These follow the formal minutes of the trustee meetings which takes from a month to six weeks to transcribe from the taped proceedings but these are regularly published in *The Journal*. The chairman of the Board has submitted a detailed report to this House and it will be found in *The Journal* and the Delegate's Handbook.

CHAMPUS

Activity in the CHAMPUS Department continues to expand and for the nine months ending July 31, 1970, a total of 11,101 have been paid and the difference of 2,430 represents many claims which were not eligible for reimbursement and 13,531 claims have been received. Of this claims which are in the IBM Department awaiting processing. The total amount paid during this period amounted to $908,478.58.

Field Service

During the year the ISMA added an additional field man to its staff to supplement the field service. He was assigned the northern part of state with Mr. Grindstaff reassigned to the central section of Indiana and Mr. Amick to the southern part of the state.

The field staff continued to call on in-

dividual physicians and to attend county medical society meetings, as well as report to members of the ISMA Board of Trustees.

Many problems were referred through the field service to the headquarters office where they were in turn either directly handled by a member of the ISMA headquarters staff or were appropriately referred to the Executive Committee, the Board of Trustees or to a commission.

The field staff additionally assisted in organizing district county medical society meetings. They also participated in staff conferences in the headquarters office throughout the year, for the purpose of administrative direction and to discuss problems in various areas of the state. In many instances the field staff was directed to emphasize certain programs of the commissions or the Board when making contact with the membership.

Following the primary elections, the field staff has been active in contacting all nominees for the Indiana General Assembly. The field staff will be registered as ISMA lobbyists during the forthcoming legislature and will be on constant duty at the State House when the legislature convenes. They will observe all bills dealing with health matters and report directly to the Commission on Legislation which will meet weekly during the session.

In addition, the field staff assists the headquarters staff in all functions of the ISMA. Each man has assignments for Board meetings and other such functions. This year the staff, for example, assisted in helping to manage the Hoosier Teen Health Happening by supervising the large body of students and further assisting in a variety of ways.

Such assignments apply to the conduct of the convention and each field secretary has specific duties in seeing that the convention runs smoothly and effectively.

Hoosier Teen Health Happening

The one program conducted by the Indiana State Medical Association this year which had the greatest public relations impact was the "Hoosier Teen Health Happening."

The reaction of students, teachers, parents, state officials and officials of other organizations has been an overwhelming response of praise and commendation to the association for this activity.

A voluminous number of letters have been received supporting this evaluation, and the survey forms which were returned to the association demonstrate an overwhelming expression of gratitude to the association.

Follow-up activity has been another gauge of the value of the program through utilization of the audio tapes now being used in the school systems throughout Indiana. In the one month following the event and prior to school closing, more than 250 of the tapes were loaned to schools from the tape library. Many schools have purchased tapes for permanent placement in school libraries.

In addition, the association is now developing 16-millimeter, black and white films on each of the presentations and these are to be publicized for use beginning in the fall of 1970.

The event was broadly publicized through the headquarters which led to reporters, radio and television newsmen on the scene throughout the day and a half hour program interviewing students and program participants alike.

This coverage, of course, was in addition to the live coverage by WFBM-TV, Channel 6, Indianapolis.

The success of the Indiana program has been additionally publicized by the AMA. The officers of the association appeared in a 30-minute closed circuit telecast of the event in Chicago during the AMA convention, and AMA representatives on the scene of the "Happening' are developing interview material and slides from the program which will be utilized as radio and television spot announcements throughout the nation.

Speakers Bureau

The association has organized a speakers bureau of approximately 40 members of the association, who will be available for county society meetings, district society meetings, and meetings of other lay and professional organizations. This can only reflect favorably upon the association's public relations. The bureau is to be publicized to county societies and other lay and professional groups.

Relations with Communications Media—Public Relations—

The headquarters office continues to maintain good relations with the media throughout Indiana by assisting reporters and radio and television newsmen with requests for information. Many stories have appeared in Indiana newspapers favorable to the profession through the assistance given by the headquarters office, and many have not appeared which would have been unfavorable because of factual information provided to reporters through the headquarters office.

On the other hand, many stories which reflect poorly upon the profession emanate from Washington, D.C. sources. An example was this year's Medicaid story originating in Washington which accused many physicians, including five in Indiana, of overchaiging for Medicaid cases. A prompt investigation by the headquarters revealed several errors and falsifications in the story and resulted in a story or rebuttal which appeared throughout the state. The president and the executive secretary appeared on several radio and television interviews to offset the allegations in this particular story.

In other activities, the staff of the ISMA wrote the story on Tell City physicians organizing a 24-hour medical service for their community; and it was, subsequently, published in the state editions of *The Indianapolis Star* and some southern Indiana papers. Copies of the story were sent to the AMA for their use and to *The Journal* of ISMA for its use.

Good public relations for the profession continues to be a major concern of the staff of the ISMA, three of whom have had lengthy experience in the newspaper, radio and television fields.

Every event which has good news value is capitalized upon to every extent possible. The "Happening" was an outstanding example of this type of event. "The Tell City Story" was another such event involving physicians doing something noteworthy concerning a community problem. Another event was the Hendricks County Medical Society inviting students, interns and residents to a special meeting to encourage them to consider Hendricks County as a place to practice.

There are many activities of the association which are internal in nature which do not lend themselves particularly to news releases, such as the important malpractice survey of physicians which was conducted by the Commission on Medical Economics and Insurance. As the commission finalizes plans in this area, it could result in story material of newsworthiness because its activities may have certain implications for the public at large who are patients.

Meetings

Planning and deliberations through meetings of the Board of Trustees, the Executive Committee and commissions of the ISMA result in the format for action by the association.

From November, 1969, to July 15, 1970, the association was involved in over 80 meetings. Most of them were held in the headquarters office of the association.

Some of the meetings included in this programming schedule were of the following groups, many of which constituted

ublic relation projects in which the association was involved:

Board of Trustees
Executive Committee
Nearly all of the commissions and committees, of which there are 20
Student American Medical Association
Special meeting of commission chairmen and officers
Indiana Health Council
Indiana Public Health Association
Indiana Society of Association Executives
Indianapolis Public Relations Society
Indiana Chapter—Public Relations Society of America
Indiana Youthpower Conference
Indiana Association Executives Association
Staff meetings
Inter-staff Meetings—Indiana Tuberculosis Association, Indiana State Board of Health
Committees of the Board of Trustees
American Medical Association meetings
AMPAC meeting in Washington
Washington legislative visitations
Planning meetings for Hoosier Teen Health Happening
Joint meeting of Indiana Hospital Association and ISMA
Press conferences
Governor's Advisory Committee on Emergency Medical Services
Convention planning meetings
Congress on Occupational Health
Conference of State Society Mental Health Committees
Congress on Medical Education
Conference on Socio-Economics of Health Care
Conference of state chairmen of Medicine-Religion Committee
Congress on Medical Ethics
Public Affairs Conference
Conference on Voluntary Health Agencies
Conference on Physicians & Schools
Woman's Auxiliary meetings and conferences
Conference on Quackery
Conference of Medical Society Executives
Conference of Senior Medical Executives
SMJAB Conference
Pharmaceutical Manufacturers Association.
10 State Medical Society and Executives Roundtable
AMA Conference on Maternal and Child Care
Seminar on Foundations for Medical Care
AMA Legal Conference
AMA Conference on Health Manpower
AMA Communications Institute

These do not include meetings of the officers and other representatives of the association who met with officials and students of the Indiana University School of Medicine and officials of the State Welfare Department, Blue Shield-Blue Cross, Regional Medical Programs, Comprehensive Health Planning and others. In addition, staff conferences were held almost daily with individuals representing an array of associations and organizations with an equal array of proposals, problems and recommendations.

In all of these and all other activities, the staff of the association is involved as they follow the direction of the officers, the trustees and commission chairmen.

Emergency Medical Services

Emergency medical services have received widespread publicity in Indiana through the activities of the Commission on Emergency Medical Services. Dr. John Farquhar, chairman of this commission, has appeared in numerous radio and television interviews and has precipitated a number of stories on the need for improving such services in Indiana. The program of highway sign markers pointing the way to emergency medical facilities has elicited national attention, with the Illinois State Medical Society and Texas Medical Association showing interest in the project as well as national and state Jaycees.

The Convention

The convention of ISMA continues to be a highlight of publicity activity during the year. The ISMA convention unquestionably produces more inches of space in newspapers, statewide, than any other event in Indiana with the possible exception of the 500 mile race in Indianapolis which, of course, is a month-long extravaganza.

Indiana Physicians on AMA Councils and Committees

Baxter, Neal E., M.D.—Council on Occupational Health; Committee on Aerospace Medicine
Behnke, Roy H., M.D.—Residency Review Committee in Internal Medicine
Booher, Norman R., M.D.—Council on Voluntary Health Agencies
Brown, Frederic W., M.D.—Council on Health Manpower; Residency Review Committee for Orthopedic Surgery
Buchanan, Wallace D., M.D.—Inter-Specialty Committee; Vice-Chairman, American College of Radiology
Egger, Ross L., M.D.—Advisory Committee on Continuing Medical Education
Farquhar, John S., M.D.—Chairman, Emergency Medical Services Committee
Gardiner, Sprague H., M.D.—Committee on Health Care of the Poor; Chairman, Committee on Maternal and Child Care; Alternate Delegate, Section on Obstetrics and Gynecology
Green, Frank H., M.D.—AMA Disability Insurance Claims Review; Committee on Private Practice
Hunter, Charles A., M.D.—Residency Review Committee for Obstetrics-Gynecology
Montgomery, Lall G., M.D.—Delegate, Section on Pathology
Nourse, Myron H., M.D.—Alternate Delegate, Section on Urology; Residency Review Committee for Urology
Owsley, Guy A., M.D.—Chairman, Council on Medical Service; Chairman, Committee on Government Medical Services
Ramsey, Frank B., M.D.—President, State Medical Journal Advertising Bureau
Steen, Lowell H., M.D.—Committee on Community Health Care; Ad Hoc Committee, Council on Medical Services, Medical Foundations

Your secretary is serving his 15th year as secretary-treasurer of the Conference of Presidents and Officers of State Medical Societies. This organization will be known in the future as "A Forum For Medical Affairs Sponsored by Presidents and Officers of State Medical Societies." This group conducts an annual meeting immediately preceding the opening session of the AMA House of Delegates and is the largest attended single meeting held during the AMA annual session, with attendance averaging between twelve and fourteen hundred.

What is Ahead

The year ahead will challenge your headquarters office and its staff to cope realistically with the growing critical issues facing medicine.

While having one of the lowest ratios of staff to membership in the nation—nevertheless your experienced staff core has the capability of furnishing needed support for growing responsibilities and challenges in activities.

The past year has been a busy but successful one. No previous year required more productivity in federal legislation, government relations, association programs, and special demands placed upon your association and staff.

As we look ahead at the fast changing

scene, we plan to stand ready to offer the membership additional services, such as services to the specialty groups of our state, county and district societies and the general membership. The decade of the '70's will sorely try the capacity of the association to carry out the wishes and objectives of the membership.

On behalf of our entire staff we are indeed grateful to the Board of Trustees, the officers, the official bodies of your association and to the component county and district societies for the cooperation received and for the opportunity of working in your behalf.

JAMES A. WAGGENER,
Executive Secretary

The Treasurer

HOUSE ACTION: Approved.

Inasmuch as the audit for the fiscal year ending September 30, 1969 has been published in *The Journal* of March, 1970, I will not repeat it with this report. Instead my report will deal with our financial status as of July 31, 1970.

The following is an itemized statement of the funds, including securities, of the association as of July 31, 1970.

SUMMARY OF ALL FUNDS

	Cash	*Investments*	*Total*
General Fund	$37,950.11	$264,478.11	$302,428.22
Journal Fund	1,801.42	—0—	1,802.42
Medical Defense Fund	5,640.42	25,000.00	30,640.42
Building Fund	12,979.49	—0—	12,979.49
Woman's Auxiliary	—0—	5,368.69	5,368.69
Student Loan Fund (old)	1,345.27	17,425.03	18,770.30
Kitchen Fund	—0—	5,841.27	5,841.27
Ethel Gastineau Fund	—0—	24.00	24.00
Dues Account (undistributed)	44.75	—0—	44.72
Payroll Account	4,516.70	—0—	4,516.70
Total	$64,278.16	$318,137.10	$382,415.26

LIABILITIES OF GENERAL FUND

Reserve for operating 1st quarter next fiscal year	$66,702.57
Unearned Income	42,483.96
Reserve Journal operations (1st quarter next fiscal year)	6,028.00
Due AMERF	19,625.00
Due Building Fund	58,391.41
TOTAL	$193,230.94

As of July 31 the income for the General Fund has exceeeded the budget by $2,076.82. Expenditures for this period have amounted to $258,462.54 which is $8,834.46 less than budgeted for the year. However, we still have two months remaining in the current fiscal year and our average cost of doing business amounts to $25,846.25 per month. If this average holds out for the next two months, we face a deficit for the year of approximately $30,000. The Board has voted that monies due the Building Fund for 1970 not be transferred from the General Fund but be used to wipe out the anticipated deficit in the General Fund.

This past year has seen some expenditures which have not been normal in the past, such as the Teen Health Happening, amounting to $21,849.80 and legal fees on the suit against Blue Cross of $5,000.00.

The executive committee and the Board have regularly reviewed the financial statements and the investment account at each of their meetings and the treasurer has followed the recommendations of these bodies by investing all available cash in short term bills or savings accounts in order to earn as much interest as possible.

The certified audit for the fiscal year including September 30, 1970, will not be completed in time for inclusion in this report but will be published in *The Journal* as soon as possible following receipt.

LESTER H. HOYT, M.D., *Treasurer*

Chairman of the Board

HOUSE ACTION: Approved.

As chairman of the Board during the year 1969-1970, it has been an extreme challenge and a great pleasure to serve the membership of the Indiana State Medical Association.

The major portion of the report of the chairman will be given in the form of the Board of Trustees reports covering the various areas which were charged to the Board of Trustees for activity by the House of Delegates and membership of ISMA, or those items of business which came before the Board during the course of the year which the Board itself felt needed study and action, and which it therefore undertook.

This report is merely a review of the activities of the Board which met and deliberated industriously on many occasions. There were, in fact, by the time of the state meeting in October, 1970, in South Bend, many meeting times for the Board of Trustees, seven of which involved both Saturdays and Sundays—full weekend meetings. Only on two occasions (1) prior to the special meeting of the House of Delegates in March and (2) the midsummer meeting in August, were there only one-day meetings. The amount of material and business handled by the Board of Trustees is overwhelming and you cannot appreciate the effort required until you are involved. The members of the Board (those trustees selected by you to represent you) most certainly do just that. They have done an exceptionally fine job in the past years, especially so in this last year. I want to thank each and every one personally connected with the activities of the Board of Trustees who have helped to make this past year what I believe to be a very successful one.

HIGHLIGHTS OF BOARD ACTIVITIES DURING THE YEAR 1969 THROUGH 1970

1. For the first time in association history, the officers of the association met with the staff following the 1969 convention in an informal exchange of information on programs and plans of the association. This meeting was extremely beneficial for the staff and the officers expressed their appreciation for the candid commentary on many items.
2. A committee was formulated to conduct the Hosier Teen Health Happening, which proved to be one of the outstanding public relations programs which the association has ever undertaken. This has been evident in the overwhelming resultant response to the program by students, teachers, parents, school officials, the communications industry, the medical profession and a large number of additional agencies and individuals all concerned with youth and their problems.
3. The Board endorsed the organization of a Speakers Bureau as recommended by the Commission on Medical Education and Licensure and these names which total 37 will be published in *The Journal* and further circulated to agencies and organizations for their use in programming. The subjects involved offer a broad cross section of material on socio-economic matters as well as scientific and medical material.
4. The Board gave its endorsement to Blue Shield to experiment with a panel concept of health insurance coverage involving medical organization participation with a local industry. The idea was approved contingent upon Blue Shield receiving the cooperation of a county medical society.
5. Medicaid, throughout the year, was

of prime concern. The Board endorsed sending a letter to all members of the association advising them that each member had a right to accept or reject the conditions of the Medicaid agreement and further advised each member that before accepting they should fully study the ramifications of the agreement not "only as it applies immediately but as to how it might apply to any extension of government control over the practice of medicine in the foreseeable future . . . ."

6. The Board, after considerable discussion on Medicaid and the impracticability of the program as it is now constituted, expressed the need for developing an alternate plan of a practical nature which would provide health care to the welfare segment of the population. The Board referred this matter to the Commission on Governmental Medical Services.
7. The Board investigated thoroughly the rate proposal for the physicians' program under Blue Cross-Blue Shield, further investigated other insurance carrier proposals and found that the Blue Shield-Blue Cross plan was commensurate, if not better, than other plans.
8. The Board approved and pointed out in its deliberations that any physician may have his fees compared with the usual and customary fees in his area and be told how he rates, above or below, but that it was improper for Blue Shield to supply an individual physician with records of the usual and customary charges of other physicians in his area.
9. The Board approved continued use of Blue Shield staff personnel in assisting county medical societies in organizing and developing comprehensive health planning groups.
10. The Board of Trustees, after long and careful consideration of seating the second trustee from the seventh district, moved to seat him with full privileges and referred the report of the Commission on Constitution and Bylaws to the 1970 House of Delegates of the association. The commission had reported to the Board that the House of Delegates has been in violation of the ISMA Constitution and Bylaws.
11. Although it was apparent that holding the 1970 convention in South Bend would be a financial loss, the Board, after meeting with representatives of the St. Joseph County Medical Society, moved to hold the meeting in South Bend. As an outgrowth, the chairman of the Board was directed to appoint a committee to prepare a "white paper" outlining the requirements for conventions of the ISMA.
12. Medicaid occupied many hours of discussion by the Board of Trustees during the year. One motion asked that a request be made to the director of the State Department of Public Welfare asking for the names of physicians who were participating in the program. Following long discussion, the Board rejected the motion.
13. The Board moved to extend an invitation to the AMA to hold its 1975 Clinical Convention in Indianapolis.
14. The Board reviewed two resolutions and moved that the first one be presented to the 1970 House of Delegates. The first resolution which was directed toward payments to the 75th percentile in Medicaid cases asks that the Board of Trustees appoint an appropriate commission "or body to study this problem and submit to the next annual meeting recommendations for the formulation of a suitable group to negotiate payments in the future." The second resolution, which was referred to the Commission on Medical Economics and Insurance, dealt with fee structures in view of third-party involvement and asked that a commission study the applicability of the California Relative Value Schedule for Indiana, since many physicians are now using this schedule in formulating their fee structures.
15. The Board again planned to meet with medical school faculty and students sometime in the fall to discuss, informally, matters of mutual concern in the area of medical education.
16. The Board also acted to acquire more information on the activities of the Governor's Commission on Medical Education and sought to define their relationship with this commission.
17. The Board directed that a standardized College Health Record form be formulated. This is being accomplished through the Section on College Health Physicians of the ISMA.
18. A motion to abolish the orientation program as a requirement of membership was adopted and a resolution to this effect was referred to the Commission on Constitution and Bylaws. The resolution further asks that county medical societies establish orientation programs suited to their own needs. At present the Commission on Special Activities is working on projects which would assist county medical societies in accomplishing this.
19. The Board was asked by the Commission on Medical Education and Licensure to endorse elimination of the three-year residency requirement in the state of licensure of foreign medical graduates before being licensed in Indiana. The Board rejected this proposal.
20. The Board also rejected endorsement of another motion by this commission to grant a five-year temporary license to physicians participating in institutional practice.
21. The Board reviewed, periodically, the activities of the Commission on Convention Arrangements and made suggested changes and alterations to the format of the forthcoming convention.
22. In addition, the Board at every meeting heard reports from the association's commissions which, in some instances, were taken for information and in other instances took actions on recommendations of these commissions, a number of which are referred to in this report.
23. The Board, at each meeting, also heard reports from each district trustee of the district's activities.
24. The Board directed Judge Ralph Hamill to continue to pursue the suit against Blue Cross which asked that the plan discontinue the statement in their policies that they provide professional services. Judge Hamill said that he could petition the court to make an entry of a court judgment to the effect that this constitutes the practice of medicine, therefore is objectionable and should not be incorporated in any future policy. Such a decree would have the binding effect of law. Later, Judge Hamill reported that an agreement had been reached with Blue Cross and a judgment was to be signed in the Danville Circuit Court stating that it is illegal for Blue Cross to provide professional medical services. All policies so stating were to be phased out.
25. Construction of a kitchen in the lower level of ISMA, as suggested by and planned by a special committee of the Woman's Auxiliary, was considered by the Board and was disapproved.
26. The Board considered a report from the Commission on Constitution and Bylaws concerning recommended changes on calling special meetings of the House of Delegates. The Board amended the commission report to read, "That no more than ten delegates or 34 members from each of at least three board districts be neces-

sary to call a special meeting of the House of Delegates."

27. The Board also took action to recommend to the 1970 House of Delegates that a "Medical Review Committee" be established to serve in the capacity as consultants to those county medical societies who wished to formulate such committees. These committees are often referred to as "peer" review committees.

28. The Board also spent much time planning for the special House of Delegates meeting which was held on March 15, 1970.

29. In view of much criticism of some Board decisions by the LaGrange County Medical Society, the Board invited the entire society to be the guests of the Board at the next meeting to air their views. No one appeared from the society.

30. Throughout the year the Board kept abreast of many additional matters pertaining to legislation, comprehensive health planning, medical education, licensure problems, Medicaid, Medicare, regional medical programs, affairs of *The Journal* of ISMA, employee and administration problems, paramedical assistants' programs, and an untold number of other issues.

31. Sponsorship of trips abroad by the Indiana State Medical Association was considered by the Board. County society-sponsored trips were leaving the impression through brochures published by the travel agency that ISMA is sponsoring such programs. Past actions of the Board prohibit ISMA participation in such ventures because of legal and other implications. The Board re-adopted the present policy with the stipulation there would be no objection to a county making it known that members of the Indiana State Medical Association were invited to participate in county society-planned and sponsored trips.

32. Board submitted a resolution on the Himler Report to the AMA House of Delegates in Chicago The Indiana delegation formulated the resolution which stated that an on-going, ten-member committee of the House, superseding all other existing committees, be elected by the House on a rotating term basis to extract material from the Himler Report, as a continuing program of long-range planning for the AMA.

33. Payment of outpatient diagnostic procedures in the private physician's office was pursued by the Board's Liaison Committee with Blue Cross. A joint meeting planned between Blue Shield and Blue Cross was to discuss this matter which would have the effect, if instituted through Blue Shield, of freeing more hospital beds for patients.

34. Blue Cross field men visiting hospital staffs was eliminated through efforts of the Board's Blue Cross Liaison Committee.

35. Policy for donations to charitable groups was established by the Board. Such contributions must (1) benefit physicians throughout the state, (2) be related to the medical field, and (3) be an activity with worthwhile public relations value to the ISMA.

36. Current financial position of the ISMA was discussed many times. The association is presently operating beyond its current income. In the breakdown of allocations from each member's annual dues, $3.49 is set aside for the building fund reserve. To help meet current expenditures the Board moved that the $3.49 be transferred to the General Fund for operating expenses contingent upon discussions with ISMA accountants.

37. Multitude of American Medical Association reports and resolutions to be introduced at the convention in Denver and Chicago were considered in detail by the Board and the delegates and alternate delegates to the AMA prior to these two meetings.

38. Indiana resolutions concerned with AMA public relations were formulated by the Board prior to Chicago meeting of AMA. PR resolution asked that the AMA adopt a more aggressive attitude in its publicity and PR programs.

39. Development of a 13-member grievance committee to hear complaints of individual physicians in matters pertaining to processing of claims was recommended by the Board. The president and chairman of the Board of ISMA were directed by the Board to investigate the possibility of formulating a committee comprised of Blue Shield Board members from each of the 13 medical society districts.

40. Legislation requiring reporting of venereal disease by private laboratories was supported by the Board upon recommendation of the Commission on Public Health. This legislation is to be presented in the forthcoming state legislative session. The Board also approved supporting legislation which would grant funds and authority for local health departments to seek legal opinions on public health matters from local sources, when needed. At present all legal opinions must be provided through the Attorney General's Office of Indiana.

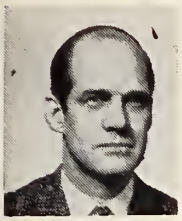
41. Commission on Medical Economics and Insurance's malpractice survey was studied and tabulated. Commission was directed by the Board to study further, and plan to incorporate any such insurance coverage into the insurance package for new members.

42. Regional Medical Programs to come under surveillance of ISMA. The Board moved that a special ad hoc committee be named to investigate RMP programming.

PETER R. PETRICH, M.D.,
Chairman

First Trustee District

HOUSE ACTION: Approved.



GILBERT M. WILHEMUS, M.D.,
Trustee

The annual meeting of the First District Medical Society was held May 7, 1970, at the Rolling Hills Country Club. The meeting was well attended with over 160 members and their wives.

Mead Johnson Company was host for our social hour preceding the dinner. David Hoy, a well known TV personality and night club entertainer, gave an excellent talk and demonstration on extrasensory perception. Dr. George W. Willison, Blue Shield Board member, reported to the group, and Dr. Gilbert M. Wilhelmus reported the past and present business activities of the Indiana State Medical Association. After the meeting the following officers were elected: Fred Smith, M.D., president; Raymond Burnikel, M.D., vice-president; Bernard Rosenblatt, M.D., secretary-treasurer. Dr. Willard Barnhart was elected First District representative on the Blue Shield Board of Directors replacing Dr. George Willison who had completed his terms as a representative. Dr. Ray Newnum was elected alternate trustee for the district.

Medicaid was started this year, and as with all new federal programs, it consumed a considerable portion of our time at several of our medical meetings.

Art Tiernan, the Executive Secretary of the Vanderburgh County Medical Society as well as secretary to the First District, retired this year. The trustee, as well as all the doctors in our district, want to thank Art for a job well done in the past and good luck in the future. The new secretary for our district is Mrs. Carol Rust—the doctors have already recognized her great industriousness and capabilities. The trustee wishes to thank the many members of the district for their cooperation and activity in their local medical societies and participating in the functions of the Indiana State Medical Association.

GILBERT M. WILHELMUS, M.D., *Trustee*

Second Trustee District

HOUSE ACTION: Approved.



JOE DUKES, M.D.
Trustee

The Second District Medical Association held its regular annual meeting at the Elks Country Club in Vincennes on May 28, 1970.

Dr. Thomas O. Barrett of Vincennes, president of the district, presided at the meeting. The program was given by Dr. John A. Galloway of Eli Lilly and Company who spoke on the practical application of insulin and related oral treatment of diabetes.

During the business meeting there was discussion of the Himler report and its opposition was recommended. Also there was discussion of Blue Shield as carrier for Medicaid. It was felt that Blue Shield should withdraw as carrier and legislators of this district should be contacted with the recommendation that welfare administration be returned to the local level.

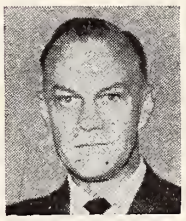
Following the business meeting a social hour and dinner was served to 54 members and their wives.

Dr. Blazey of Washington invited the district to meet there next year with the Daviess-Martin County Medical Society as hosts.

JOE DUKES, M.D., *Trustee*

Third Trustee District

HOUSE ACTION: Approved.



DONALD M. KERR, M.D.,
Trustee

After six years as trustee and five as alternate I make my final report to the membership.

The period has been one of more change in medicine, especially in the socio-economic area, than in the entire history of the profession, and it is my opinion that more change is on the way.

We have seen come to pass and had to try to deal with Medicare and Medicaid, each with new problems and new rules for the game (and rules which we did not make but which were thrust upon us by the elected officials of the patients we serve).

It is my opinion, and I have tried to act and vote accordingly, that if I believe in our system of government, I am (and you are) compelled to act within the framework of the legislation passed by our elected officials. I am confident that the vast majority of our membership does not approve of the flagrant lawlessness of our nation's protest groups, but seemingly when the officials of ISMA attempt to work through the maze of government programs on behalf of the membership, a vocal group suggests that we should somehow ignore the reality of the law and present them with a fantasy solution more to their liking—failure to do so brings about more threats of censure resolutions.

I know of no instance where the officers have been given the power to order strikes—and question the value and wisdom if they did. I know of no instance where the officers can, in the manner of union officials, order a member to do or desist from any action in the socio-economic sphere—but somehow we are supposed to negate all the laws and bring happiness to the members.

One of the values of the experience as an officer is the opportunity and the necessity to see beyond the horizons of one's own town and gain an overview of the problems faced in other than our own community. It would be useful to all the members if they could share these experiences and I suspect would alter some of the views and quiet some of the noise of the critics of the leadership. It would certainly make clear the need for the officers to attempt to act for all the members ranging from crossroads towns to megalopolis centers—and the problems and solutions are not the same for both and we are faced always with producing one answer.

I urge the membership to look at the makeup of the Board of Trustees. The majority are generalists and from small communities. By nature and conviction they are not the ultra-liberal dupes of the socializers as charged by some. I know of no leadership group in any organization with a broader base and more representative of all the members. One of the real benefits of the time served as trustee is the chance to know these men who devote much of their time (and therefore money) to working with problems of the membership. They are deserving of praise and commendation—not the ludicrous threats of resolutions of censure which come belching out of an apathetic membership—apathetic, that is, until their noses are

tweaked and they fear their purses will be likewise by their elected government officials.

It has been said that the only thing men seem to learn from history is that we don't learn anything from history. I hope the membership will help their officials alter this. Let's not wait to be dragged along by the body politic—let's be in and of it and try to aim it and, hopefully, from inside we can maintain not the status quo, but basic values of our profession in a period of world-wide socio-economic change.

My replacement, Dr. Eli Goodman from Clarksville, brings a good range of experience from within and without the organization. I am confident he will be a thoughtful and thought-provoking member of the Board. I wish him well and urge the membership to give him their support and counsel.

Thanks again.

DONALD M. KERR, M.D., *Trustee*

Fourth Trustee District

HOUSE ACTION: Approved.



ROBERT M. REID, M.D., Trustee

Organized activity in this district was limited this year. Interest in the various activities of the ISMA and the AMA, however, seemed to be increased, if the inquiries directed to the trustee can be used as a guide. Concern was expressed most frequently in matters of malpractice insurance. Comprehensive health planning and possible alternatives to be considered in increasing the supply of physicians in our area.

The district meeting was held in Greensburg on May 13, 1970. The previously discussed increase of $10.00 in district dues was passed. It is hoped that this fund after time of accummulation can be used in bettering communications within the district.

Dr. Walter Able spoke on the "Corporate Practice of Medicine." Dr. Jack Shields was re-elected as alternate trustee. The new district president for the coming year will be Dr. Gordon Fessler.

ROBERT M. REID, M.D., *Trustee*

Fifth Trustee District

HOUSE ACTION: Approved.



WILBERT McINTOSH, M.D., Trustee

The fifth district meeting was held in Greencastle at the Country Club on Wednesday, May 20, 1970. Dr. Tipton, president, presided and Dr. Cleon Schauwecker was secretary. The meeting convened at 4:00 p.m.

Many things were discussed, among them the "Teen Health Happening" which was stated to be a great success. IMPAC was also discussed by Dr. McIntosh, who told the group that much more participation was needed. Mr. Hank Kiszla, representing Blue Shield, made a report on the status of Blue Shield and its relation to Medicaid and Medicare. There was a lengthy discussion on the possibility of levying district dues and a committee was appointed to check the feasibility of hiring a district secretary to serve the district and the component counties. Mr. Amick was present, representing the Indaina State Medical Association, and discussed IMPAC, AMPAC and also the politics of medicine and the place of medicine in politics.

The new officers for the coming year were elected with Dr. William Bannon of Terre Haute unanimously elected as president; Dr. James Cristee was elected unanimously as secretary. Dr. Fred Dierdorf was elected to be the Blue Shield representative from the area.

A tentative date for next year's meeting was set for May 19th and the place to be determined later. It will either be Clay or Vigo County.

I would also like to report briefly on Comprehensive Health Planning status in Indiana. At this time Gary Miller and Fritz Harbridge are continuing to contact counties in Indiana in order to help facilitate their organizing Comprehensive Health Councils. At this time there are 17 counties already recognized by the Indiana State Board of Health and there are many more who are near completion and will be completed within the near future.

The meeting was adjourned about 6 o'clock and a dinner meeting was held later. The speaker was an attorney from Indianapolis who discussed very thoroughly the possibilities of the corporate practice of medicine and also partnerships in medicine.

Several wives attended the dinner. The meeting as a whole was well attended.

WILBERT McINTOSH, M.D., *Trustee*

Sixth Trustee District

HOUSE ACTION: Approved.



STEPHEN D. SMITH, M.D., Trustee

Again it is time for the annual trustees report from along the banks of Little Blue River. We held our annual meeting at Westwood Country Club, New Castle, starting with a golf tourney which lasted into the afternoon. At 2:30 in the afternoon we started our program which consisted of an excellent speech by Dr. Otis Bowen on "The Status of Medicine—State and Nation." This was followed by a speech of the dean of medical school, Glenn Irwin on "Horizons in Education."

We then held a business meeting with re-election of Stephen D. Smith, Knightstown, as trustee and election of Paul Inlow, Shelbyville, alternate trustee. Election of officers for the ensuing year was Dr. David Wynegar, Richmond, president; Dr. Mark Smith, New Castle, vice-president; Dr. John Moenning, Greenfield, secretary-treasurer. The 1971 meeting will be held at Greenfield at Hancock Co. Post in May, 1971.

After the business meeting there was a business meeting of the sixth district A of GP with a report from Dr. Daggy of the recent meeting. This was followed by a great dniner with golf prizes being presented.

After dinner 70 doctors and their wivcs heard a speech by Senator Roudebush.

I have been quite encouraged and well pleased with the quality of individual medical staff's continuing education programs. It is a shame that the ones that really need this are not availing themselves of it and therefore will probably force some sort of compulsory continuing education control.

STEPHEN D. SMITH, M.D., *Trustee*

Seventh Trustee District

HOUSE ACTION: Approved.



JAMES A. GOSMAN, M.D., Trustee

A special meeting of the Seventh District Medical Society held on Nov. 11, 1969, and the annual meeting of the organization, on June 10, 1970, were the principal activities of the society in the last year.

The special meeting, in Indianapolis, called by Dr. Malcolm O. Scamahorn, the president, was held to elect an additional trustee and alternate trustee from the society, offices which had been established with the adoption of a resolution by the House of Delegates of the Indiana State Medical Association in its October 1969, annual meeting.

Dr. Dwight W. Schuster, of Indianapolis, and Dr. Joseph C. Kerlin, of Danville, were elected trustee and alternate trustee, respectively.

Dr. Scamahorn requested an expression from the membership as to whether he should continue as president of the society in view of the fact that he had been elected president-elect of the state association. It was voted that he continue in the office.

At the annual meeting of the society, held at the Ulen Country Club, in Lebanon, Dr. John M. Records, of Franklin, was elected president-elect. He will succeed Dr. Ellery T. Drake, of Martinsville, in 1971. Dr. Donald E. Stephens, of Indianapolis, was elected secretary-treasurer. He succeeds himself.

Among special guests at the meeting were Dr. Peter R. Petrich, of Attica, chairman of the ISMA Board of Trustees; Dr. Glen V. Ryan, of the Blue Shield Board of Directors, and Mr. Richard C. Kilborn, president of Blue Shield, all of whom spoke briefly.

Following a dinner attended by society members and their ladies, Dr. Thomas A. Hanna, medical director of the Indianapolis Motor Speedway, discussed the 500-Mile Race and the medical and safety precautions taken for the event. The meeting and the dinner were preceded by an afternoon of golf.

During the year it was my privilege to have attended meetings of the Hendricks and Johnson county medical societies.

JAMES H. GOSMAN, M.D., *Trustee*

Seventh Trustee District

HOUSE ACTION: Approved.



DWIGHT W. SCHUSTER, M.D., Trustee

As a trustee for the seventh district, I have attended all meetings of the Board since my being seated in January, 1970. I also have attended the monthly board meetings of the Marion County Medical Society and one meeting of the Morgan County Medical Society.

With these meetings, as well as individual contacts with members of the four component county societies of the seventh district, I have served as a communication link between the state association and the county societies. This half-year has been a cooperative and satisfactory period, and I look forward to continuing mutually satisfying relationships.

DWIGHT W. SCHUSTER, M.D., *Trustee*

Eighth Trustee District

HOUSE ACTION: Approved.



RICHARD INGRAM, M.D., Trustee

The Eighth District Medical Society held its annual meeting June 3, 1970, at Green Hills Country Club, Muncie, Indiana. Guests included Dr. Malcolm Scamahorn, president-elect, ISMA, Mr. Herb Dixon of Indiana Blue Shield, and Mr. Howard Grindstaff of ISMA.

District elections were held and Dr. Eugene Gillum of Portland was elected Eighth District Medical Society president while Dr. William Cripe was elected secretary-treasurer. The alternate district trustee's position previously held by Dr. Paul Sparks of Winchester was filled by the election of Dr. R. D. Williams of Anderson.

The past year has brought changes in medicine and a look at the future—neither of which has been pleasing to the majority of eighth district members. As I have talked to men over the district no doubt the biggest single point of contention that falls within the purview of the ISMA is the proposed inauguration by Indiana Blue Shield of an experimental panel practice plan in a selected Indiana county. I am sure it is well known that this was one of the major portions of the discussion at the March special meeting of the House of Delegates. While many members of our district were unhappy with the actions of that meeting, at least there was general agreement that such a forum for open discussion of our problems was valuable.

In this, my first year as a trustee, I have become more acutely aware of the forces at work to destroy any vestige of free enterprise in the field of medicine. In my opinion, if we are to have any hope of preserving our system of medicine which has been beneficial to both our patients and ourselves, we must now take these steps:

1) Become active in local, district and state medical affairs.
2) Become active at all levels in the political affairs of our nation.
3) Be willing to have the courage and to make any financial sacrifice necessary to say NO when presented with schemes which we believe will be detrimental to our patients' welfare and, since the welfare of our patients and our own welfare are directly proportional, ultimately detrimental to our own welfare.

RICHARD G. INGRAM, M.D., *Trustee*

Ninth Trustee District

HOUSE ACTION: Approved.



PETER R. PETRICH, M.D., Trustee

The Ninth District Medical Society met in March of 1970 and in June of 1970. The first meeting took place in Lafayette, Indiana, and was a meeting of the delegates and trustees with the purpose of discussing some changes in the structure of the district society and to perhaps give better direction to its activities.

The June meeting took place with the Montgomery County Medical Society as the host at the country club in Crawfordsville. It was an excellent turn out with the scientific session in the afternoon which was attended by approximately 30 physicians.

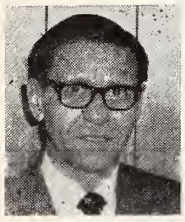
The evening affair was very well attended with an excess of 100 persons in attendance. A very fine program, all in all, and the activities of the district were certainly enhanced by this sort of a get-together.

The important piece of business for the district was that the delegates to the district meeting voted for an increase in dues structure from $1 to $3 for the society membership. Dr. William Sholty was elected to succeed Dr. Petrich as ninth district trustee, and Dr. Barton Bridge was re-elected to represent the district on the Blue Shield board.

PETER R. PETRICH, M.D., *Trustee*

Tenth Trustee District

HOUSE ACTION: Approved.



VINCENT J. SANTARE, M.D.,
Trustee

The tenth district meetings this past year were the most unusual and best attended in several years.

The first meeting held was on September 24, 1969. An overflow crowd attended this meeting presided over by Dr. Ray Doherty, tenth district president. During dinner, an election of district officers was held, resulting in the election of Dr. Robert Milos, president, and Dr. J. M. Siekierski, secretary.

Attendance at this affair was directed to fathers and their sons or daughters, and featured Johnnie Latner, Notre Dame All American Heisman and Maxwell Trophy winner and Pittsburg Steeler star. Mr. Latner was introduced by Dr. Joseph Kopcha, president of the Lake County Medical Society and former Chicago Bear star. Mr. Latner made an unusually interesting talk about professional football and showed an excellent film on the 1968-69 season of the Chicago Bears.

The second meeting was held May 13, 1970 at the Phil Smidt Restaurant. Presiding at dinner was Dr. R. Milos, president tenth district, who introduced Dr. Santare to approximately 120 doctors and their wives.

Dr. Santare stated he would not give the tenth district report at this meeting to save time for the program, but he briefly outlined some of the events that were taking place in the state. Dr. Santare then introduced T. C. Tyrrell, alt. AMA delegate; Herb Dixon, V. P., Blue Shield, the future assistant executive director, Ed Mesterharm, and the tenth district secretary, Dr. J. Siekierski. The minutes of the October meeting were approved. Dr. Siekierski greeted the membership and said a few words as district secretary.

Dr. Milos then introduced Dr. L. W. Neal, president of L.C.M.S. Dr. Neal congratulated the Intrav Agency for conducting such a well-organized trip for the membership, and said he hoped to have future trips with Intrav as everyone was so well pleased with the way they handled all the arrangements.

There was no further business, so Dr. Neal then introduced his brother, Victor Neal of Oregon State University. Mr. Neal presented a very interesting program on oceanography and showed slides of this very fascinating science. Following a question and answer period by Mr. Neal, the meeting was again turned over to Dr. Milos, who thanked Mr. Neal for an enjoyable and informative evening for all.

Your district trustee has made regular monthly reports of state association affairs at the societies in the district, and this has proven to be of considerable value to the county societies.

V. J. SANTARE, M.D., *Trustee*

Eleventh Trustee District

HOUSE ACTION: Approved.



LOWELL J. HILLIS, M.D.,
Trustee

The 1969 meeting of the Eleventh Trustee District was held at Emly's Restaurant, Marion, Indiana, September 17, 1969.

The business of the district was conducted in the afternoon session and the new officers elected were: president—Dr. Julius Steffen; secretary-treasurer—Dr. Fred Poehler, re-elected. Dr. Lowell J. Hillis of Logansport was re-elected to his second term of office as trustee of this district.

The program was outstanding. The speakers were all from the military service and their subjects were space medicine and undersea medicine. These talks were well received and there was considerable discussion among the membership concerning the program. The attendance at this meeting was excellent, this probably being one of the best attended meetings in the recent years.

The next meeting of the Eleventh Trustee District will be September 23, 1970, at the Holiday Inn in Wabash, Indiana. Another excellent program has been planned for this meeting.

Various county activities in this district have again been known as largely associated with comprehensive health planning. Cass county is progressing very well, especially in the planning of health facilities. The committee on health facilities of our comprehensive health group has been very active in projecting facilities for at least the next ten years.

Your trustee has attended several fine meetings within the district, especially those held in Wabash and Miami counties. Many discussions have been had investigating methods of invigorating and increasing the interest and attendance at all local meetings of organized medicine.

Again it may be said that most of the activities in this district may be described as "business as usual."

LOWELL J. HILLIS, M.D., *Trustee*

Twelfth Trustee District

HOUSE ACTION: Approved.



WILLIAM R. CLARK, SR., M.D.,
Trustee

During the past three years, as I reported in my previous reports to the ISMA annual meeting, the district has been going through reorganization. I can say with real satisfaction that it has begun to pay off. We had four meetings of the new board of directors, not including the annual meeting held in May. The attendance at these meetings can be improved upon. However, at the annual meeting, over 80 members were in attendance.

I believe that more interest in organized medicine has taken real roots and that real concern for the future welfare of our profession is being manifested. This statement is proven by the fact that seven of my eight counties responded *promptly* to a letter I sent out asking for the names of their new officers and for the names of physicians who would volunteer their services to the various state committees and commissions. Definitely more interest has been shown in the Board of Trustees and the various county meetings I attended. This is really healthy.

Our annual meeting was held on May 20th at the Chamber of Commerce in Ft. Wayne. The following guests were present: Malcolm Scamahorn, M.D., president-elect of the ISMA; Peter R. Petrich, M.D., ninth district trustee and chairman of the Board; Otis Bowen, M.D., thirteenth district trustee; Mr. John Walters, field service, ISMA; Congressman Richard L.

Roudebush, Fifth District State Representative and Congressman E. Ross Adair, Fourth District State Representative.

John Hartman, M.D., president of the twelfth district, presided. New officers named were: George C. Manning, M.D., Ft. Wayne, president; Franklin A. Bryan, M.D., Ft. Wayne, vice-president; W. Bradley Hughes, M.D., Waterloo, secretary-treasurer; William R. Clark, Sr., M.D., Ft. Wayne, re-elected trustee; Kenneth F. Isenogle, elected twelfth district representative to the Indiana Blue Shield board of directors.

That evening we were treated to a talk by Congressman Richard L. Roudebush, principal speaker, on "Happenings in Washington" and Congressman E. Ross Adair on "Why We Are In Cambodia." Both talks were excellent and informative. I am sure every member and guest will long remember their remarks.

I want to thank the outgoing officers for their leadership and co-operation during the past year and my thanks to Dr. Fred Schoen, my alternate. I especially want to thank my counties for their increased interest and their co-operation.

I, as your trustee, along with the new officers and board of directors of the twelfth district, look forward to the combat we must face in the future to moderate change and effectively make the future of our profession respected and restored to the high principles we have experienced in the past.

WILLIAM R. CLARK, SR., M.D., *Trustee*

Thirteenth Trustee District

HOUSE ACTION: Approved.



OTIS R. BOWEN, M.D., Trustee

The physicians and various county medical societies were very busy and active this past year. Last September 17, 1969, the district meeting was held at the Morris Inn at Notre Dame. The attendance, although disappointing, was still perhaps a little bigger than average. The afternoon program was stimulating and provocative, the social hour was delightful, and the evening's banquet and entertainment was exceptionally good. The speaker, Mr. Ray Stanish, was a professional one and talked very entertainingly and very authoritatively on the subject of atomic energy. He explained atomic energy in simple terms and thus entitled his talk, "Atomic Energy—Peasant Style."

The 1970 meeting is scheduled for September 3rd at Elkhart. Plans are being made at the present time for an outstanding program. Attempts to stimulate attendance are also being planned.

Marshall County Medical Society has completed a year of outstanding monthly educational meetings. Dr. Stoller has been the organizer for this upsurge of regular informative sessions. Each has been preceded with a dinner. Members of adjacent county medical societies have been invited and have responded quite well in attending.

The St. Joseph County Medical Society has been busily occupied with committee work in preparation for the 1970 Indiana State Medical Association's meeting to be held in South Bend. Preliminary activities point to an outstanding meeting in October for all physicians of the state.

A survey is being conducted by the district's trustee among the membership of the five smaller counties to determine if the previously heard numerous suggestions for a merger were strong enough to warrant such a step. A questionnaire was prepared and mailed to every physician in Fulton, Marshall, Pulaski, Kosciusko and Starke counties to reflect the views of each physician. To date, the response has been about 50% in spite of the fact the questionnaire would take but 30 seconds to complete. Follow-up will be done. No conclusions can be reached yet.

OTIS R. BOWEN, M.D., *Trustee*

Editor of The Journal

HOUSE ACTION: No action.

Advertising revenue is a little below that of previous years but adjustments in the size of the issues will enable *The Journal* to live within its budget.

This year, for the first time, the Roster issue carried a specialty designation for each member. This was an expensive changeover, since the entire county society portion of the roster was reset. In the future the type for the Roster will be reset only for new additions and changes, and the added expense will not recur.

In addition to the customary special issues on the Heart and Circulatory System, on Malignancy, and for General Practice and the Annual Convention, special stories were carried on the Katherine Hamilton Mental Health Center in Terre Haute and the new Indiana University Hospital in Indianapolis, and an issue in honor of Dr. Goethe Link was published in July.

A special readership interest study was conducted this year. Reader interest in nine state medical journals, of which *The Journal* was one, was measured in relation to 13 major nationally-circulated magazines and journals. The state journals scored very well, and were either second or third in preference among the 14 publications. This will undoubtedly enhance our standing in the advertising world.

The scientific content continues to be well supported by many contributors.

FRANK B. RAMSEY, M.D., *Editor*

Delegates to AMA

HOUSE ACTION: Filed for information.

Indiana's full contingent of delegates and alternate delegates attended the 121st annual convention of the American Medical Association, June 21 through 25 in Chicago.

Accompanying the delegation were Drs. Lowell H. Steen, Hammond, president; Malcolm O. Scamahorn, Pittsboro, president-elect and Peter R. Petrich, Attica, chairman of the Board.

The delegation chaired by Dr. Eugene F. Senseny, Fort Wayne, reviewed all of the advance material distributed prior to the meeting and met every morning during the five-day session at breakfast to consider late resolutions introduced to the AMA House, as well as plan voting strategy on many of the major issues. The delegation also met at noon each day to continue deliberations.

All four AMA presidential candidates met with the Indiana delegation prior to the Thursday morning elections as well as candidates for other offices of the AMA including the Board of Trustees. Under the circumstances the Indiana group had an excellent opportunity to hear each candidate's personal platform.

A former president of the Indiana State Medical Association, Dr. Guy A. Owsley, Hartford City, was elected chairman of the important AMA Council on Medical Service during the session.

Indiana's delegation included Drs. Don E. Wood, Indianapolis; Frank H. Green, Rushville; Jack E. Shields, Brownstown; John S. Farquhar, Fort Wayne, and Eugene F. Senseny, Fort Wayne.

Alternate delegates included Drs. James A. Harshman, Kokomo; Eugene S. Rifner, Van Buren; Kenneth O. Neumann, Lafayette; Patrick J. V. Corcoran, Evansville; and Thomas C. Tyrrell, Hammond.

Also on hand to meet with the delegation throughout the week were Drs. Sprague H. Gardiner, Indianapolis delegate from the AMA Section on Obstetrics and Gynecol-

ogy; Lall H. Montgomery, Muncie, delegate from the AMA Section on Pathology and Physiology and Myron H. Nourse, Indianapolis, alternate delegate from the AMA Section on Urology.

Indiana's delegation introduced two resolutions to the House of Delegates: one asked for a more aggressive AMA attitude in its communications and public relations programs while the other asked that the Himler Report be referred to a new Committee on Planning and Development for continuous evaluation as a part of long-range planning for the AMA.

The communications resolution was referred to the Board of Trustees of the AMA.

Concerning the Himler Report and long-range planning and development, the Indiana resolution asked that the committtee be a committee of the House, constituted of nine members of the House and one AMA trustee.

Indiana's resolution and others on the same subject caused one of the longest debates of the House with the final recommendation including a nine-member council made up of four appointed by the speaker of the House (two from the House and two from the membership at large); four appointed by the AMA Board of Trustees (two members of the Board and two members from the membership at large). The ninth member is to be appointed by the president of the Student American Medical Association.

Some of the other Indiana officers in attendance at the meeting were Drs. Burton E. Kintner, Elkhart, member of ISMA Executive Committee; Lester B. Hoyt, treasurer, and Hugh K. Thatcher, assistant treasurer of the association, both of Indianapolis; Lowell H. Hillis, Logansport, ISMA trustee; Dwight W. Schuster, Indianapolis, ISMA trustee; Frederic L. Schoen, Fort Wayne, alternate trustee and G. Beach Gattman, Elkhart, alternate trustee.

In its first uninterrupted Annual Convention since 1967 (thanks to the most elaborate security precautions ever taken), the House of Delegates considered a record volume of business; passed a hotly debated statement on abortion; raised membership dues to help finance needed programs; heard outgoing president Gerald D. Dorman challenge the association to attain and maintain a specific minimum health standard of "a healthy child and a healthy mother;" and applauded newly inaugurated president Walter C. Bornemeier's call for greater emphasis on patient care through an overhaul of medical education and training.

Elections

Wesley W. Hall, Nevada, was elected president elect, defeating two other trustees and one delegate running for the position. Dr. Hall will become the 126th president of the AMA in June, 1971.

H. Thomas McGuire, Delaware, was elected vice president and Russell B. Roth, Pennsylvania, and J. Frank Walker, Georgia, were unanimously re-elected to their posts as speaker and vice speaker of the House, respectively.

John H. Budd, Ohio; Richard E. Palmer, Virginia; James H. Sammons, Texas; and Kenneth C. Sawyer, Colorado, were elected to fill the four vacancies on the Board of Trustees.

George W. Petznick, Ohio, was re-elected to the Judicial Council.

M. Louise C. Gloeckner, Pennsylvania, was elected to the Council on Constitution and Bylaws.

Warren L. Bostick, California, and Bernard J. Pisani, New York, were elected; and Bland W. Cannon, Tennessee, was re-elected to the Council on Medical Education.

Paul W. Burleson, Alabama, was elected; and Donald R. Hayes, Massachusetts, and W. B. Hildebrand, Wisconsin, were re-elected to the Council on Medical Service.

Final Report and Inaugural Address

In his final report to the House, Gerald D. Dorman reminded the profession that "We expect to be recognized and accepted as the leaders of medical and health care planning and action . . . because our experience has made us the best qualified to give leadership in medical care. But if we are to continue in that position, we must earn it. We must deserve it, not because of reputation or tradition, but because of visible achievement . . . ."

After repeating his hope (first stated in Denver) that the 1970's would be the Significant Seventies in medical and health care, Dr. Dorman said, "I should like to set a specific minimum health standard for the American Medical Association to attain and maintain. That is a healthy child and a healthy mother. This does not require a resolution of this House; it does not require legislation or funding. It only requires personal dedication and commitment.

"Already this is being carried out in many places that I know of, and surely in many that I do not. Already the infant and maternal death rates are falling, but I speak also of infant and maternal morbidity. There are lives of mothers and of children permanently damaged for lack of proper care. This is not necessarily a fault of organized medicine because poverty, ignorance, malnutrition and bad sanitation take their toll. These we, as crusading citizens, must overcome now, as leaders in our drive for a healthy child and a healthy mother . . . .

"I want to see all our physicians—our obstetricians and gynecologists, our pediatricians, our general practitioners, our internists and other specialists—renew their contact with the rest of the health team and rededicate themselves to this minimum health standard . . . throughout our population."

Walter C. Bornemeier, in his inaugural address as the AMA's 125th president, cited five areas for improvement in medical education and training: shortening the medical school curriculum; modernizing and shortening residency programs; relating more medical training to patient care at an earlier point; assimilating full-time teachers into patient care; and reducing the number of medical research institutions and researchers.

"In any new graduate program, we might be advised to emphasize again a preceptorship method of training," he said. "If M.D. graduates could be trained in the active practice of medicine outside the hospital with a physician or group approved for teaching, the doctor shortage would in large measure be solved." He pointed out that such training would emphasize what makes people sick as well as how to make them well again.

Those changes would allow the physician to undertake more rapidly the responsibility "commensurate with his skills and knowledge" and might "overnight add 50,000 doctors to the care of patients in our communities."

Dr. Bornemeier praised medical schools for moving in the right direction. He advocated a goal of six years from high school to the M.D. degree and added that in some schools, first-year students can go directly into a patient-oriented curriculum because "the conventional freshman year in medicine is being given as the final year" of pre-med schooling.

The president said there are now some 35,000 M.D.s in residencies who, 25 years ago, would already have been in active practice. Another 5,000 physicians have quit practice to assume positions as medical educators in hospital residency training programs. And another 10,000 to 12,000 M.D.s are full-time educators in medical schools, a function that 25 years ago "was done by those of us in practice."

The House heard other brief speeches from the president of the National Medical Association; the chairman of the AMPAC Board; and the president of SAMA.

House Actions

From June 21 through June 25, the House was in business sessions for 17 hours and 15 minutes, during which it considered a record 201 items of business. Included were 61 reports — 31 from the Board; three from the Judicial Council; six from the Council on Constitution and Bylaws; 10 from the Council on Medical Education; five from the Council on Medical Service; and six special reports. It also dealt with 140 resolutions — eight un-numbered memorial or commendatory ones; 27 special ones generated by the (Himler) Committee on Planning and Development; and 105 from regular sources.

Abortion: After long debate before the reference committee and on the floor of the House, delegates adopted the following statement on abortion:

"Whereas, abortion, like any other medical procedure, should not be performed when contrary to the best interests of the patient since good medical practice requires due consideration for the patient's welfare and not mere acquiescence to the patient's demands; and

"Whereas, the standards of sound clinical judgment, which, together with informed patient consent should be determinative according to the merits of each individual case; therefore be it

"Resolved, that abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in an accredited hospital acting only in conformance with standards of good medical practice, and after consultation with two other physicians chosen because of their professional competence, and within the Medical Practice Act of his state; and be it further

"Resolved, that no physician or other professional personnel shall be compelled to perform any act which violates his good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional personnel withdraw from the case so long as the withdrawal is consistent with good medical practice."

Consumer Forum: For the first time in its history, the House appointed a special reference committee to hold a public forum, at which individuals and representatives of groups could present their views of medical and health care. The committee heard three hours of testimony on the opening day of the convention. From its report, the House adopted the following recommendations:

"That consideration be given by the Board of Trustees to the creation of a multi-ethnic advisory committee on health care problems of minority groups.

"That the House of Delegates reaffirm its policy of encouraging physicians, as well as paramedical personnel, to continue to provide compassionate and sympathetic care to all patients.

"That the House of Delegates reaffirm Resolution 62, Annual Convention 1969, which states in part: 'It is a basic right of every citizen to have available to him adequate health care' . . . and that 'the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person.'

"That the AMA Advisory Committee on Health Care of the American People be invited to participate in reference committee hearings" of this type if they are held in the future. Consideration of having such an open forum at each AMA convention was referred to the Board of Trustees.

Dues Increase: Until this convention, the amount of AMA dues was prescribed by the Board, for adoption or rejection by the House. On Tuesday, however, the House amended the bylaws to give itself that responsibility. Chapter III, Section 1 (A) of the bylaws now reads:

"(A) How Prescribed - Annual dues for any year shall be prescribed in an amount fixed and determined by the House of Delegates. The Board of Trustees may submit recommendations to the House on the fiscal needs of the association and the level of dues. Dues fixed by the House shall remain in effect until changed."

In response to Board Reports A and B (financial statement of the AMA, and background detail on the need for an increase), the House voted to increase annual AMA dues by $40, to $110. At the same time, the House directed that "basic and explicit information supporting the need for this dues increase, and future dues increases, be promptly disseminated by the AMA to individual members by every reasonable and available means possible; and that the aid of constituent state associations be enlisted in this effort."

The new dues will become effective with the next fiscal year, beginning December 1, 1970.

Recommendations

That the AMA reaffirm, as a statement of the primary purpose and responsibility of the association and the medical profession, "the promotion of the art and science of medicine and the betterment of public health," and, as part of this purpose, apply all possible effort to make medical service of high quality available to all individuals.

That the association has the duty to guide and assist the medical profession in the attainment of this objective.

That the American Medical Association recognize the need for multiple methods of delivering medical services, and that it encourage and participate in efforts to develop them.

That, in the interest of attracting the most highly qualified candidates to the field of medicine, it simultaneously make every effort to maintain and create incentives in medical practice. Among these incentives are a multiplicity of practice options, maximum professional independence and freedom of choice for both physicians and patients.

Health is a state of physical and mental well-being.

That the AMA expand its active role in planning and developing programs for medical care in all of its ramifications and that it encourage and assist state and county medical societies to do the same at their respective levels.

That, clearly recognizing the health of individuals has many aspects other than medical care, such as education, housing, environmental control, transportation, civil rights, and the alleviation of poverty, the American Medical Association continue to show an active, innovative and constructive interest in these non-medical components of health services.

That the AMA and the constituent and component medical societies seek the active cooperation of all physicians, both as individuals and as members of medical staffs, in medical service projects for areas in need of medical services.

That the AMA, through its Council on Health Manpower, in conjunction with county and state medical societies and other professional, education, and lay associations, continue to explore and develop expedients to overcome health manpower shortages.

That the association, in its future declarations and activities directed toward the alleviation of shortages in health services and personnel, underscore the fact that these shortages are not due merely to an insufficient number of health professionals across the board, and emphasize that maldistribution of practitioners geographically, by profession, and by specialty is an equally important factor in depriving communities of an adequate supply and spectrum of health services.

That the association publicize the reasons for the maldistribution, as outlined in this section, and stress that the voluntary cor-

rection of these deficiencies requires public cooperation and community action in addition to the measures taken by the health professions.

That an appropriate committee of the AMA immediately begin to formulate a policy on physicians' assistants, particularly with regard to their responsibilities, limitations on their services, and supervision of their services by qualified physicians.

That the AMA reaffirm the principle that the basic responsibility for the medical care of patients lies with their physicians of record and that that responsibility cannot be legally or morally delegated.

That the AMA approve in principle certification of educational programs for physicians' assistants but oppose licensing of these individuals by any state agency.

That the association's Law Division upon request assist the state medical societies in identifying and avoiding any legal hazards that may accompany the employment of physicians' assistants.

In seeking as its goal the highest quality and availability of patient care, the American Medical Association advocates factual investigation and objective experimentation in new methods of delivery of health care, while still maintaining faith and trust in the private practice of medicine and pride in its accomplishments.

That the association, in appropriate public statements, emphasize the concept that differences in education, state laws, culture and income levels create problems that may necessitate different systems of delivering medical care for different population groups and different geographic areas.

Urge state medical associations to establish bureaus or departments of economic research, development and planning to study, develop and disseminate data concerning the economic aspects of medical practice.

Through the AMA's Departments of Survey Research and Economic Research, continue to assist state associations in collecting such data and to act as a clearinghouse for data so gathered.

Encourage state medical associations to designate representatives to deal energetically with third party agencies and programs, utilizing the concept of usual, customary or reasonable charges.

That the AMA reiterate its support of sound, existing mechanisms, such as public grievance and adjudication committees, and utilization and peer review committees, which state and county medical societies have found to be most appropriate and effective for the consideration of fees and the costs of medical and related care.

Endorse the principle of voluntary, lifelong postgraduate study for all physicians and continue and accelerate the development of programs and incentives for such study.

That the AMA encourage and assist all state medical associations to devise programs for voluntary post-graduate study designed to maintain medical education at the optimum level with the primary objective of assisting the physician in rendering professional services to his patients. These programs of postgraduate study should be mindful of the many demands on the time of the busy physician, and his responsibilities to his patients and his practice, and should be least disruptive to the provision of medical services.

That the association obtain information from each state medical society as to whether special requirements have been imposed on physicians who render services to patients under the provisions of tax-supported programs and obtain the specifics of what those requirements are.

That in those states where the health or welfare departments have imposed special requirements on physicians to participate in their programs, the medical society reject those requirements and that, if the need for such regulation can be demonstrated, the state medical society, education department, and health department cooperatively develop standards to be incorporated into the education law and enforced on all physicians of that state, thereby eliminating double standards for m dical practice and restoring the licensing authority to the proper agency.

The AMA, on the basis of the data received from the state medical societies, (1) continue to identify the services that comprise good medical care; (2) develop guidelines that state and county medical societies may use in evaluating needs and priorities of medical services in their respective areas, and (3) ensure that these data and guidelines are widely distributed and publicized.

That the present structure of the association be retained and that it be strengthened by improvements and modifications in its function.

That on implementation of the program for organization and reorganization, a planning council with appropriate subcommittees be formed for the purpose of processing data and formulating policy recommendations for the consideration of the Board of Trustees and the House of Delegates.

Education: In December, 1968, the House agreed that "an ultimate goal is unification of the internship and residency years into a coordinated whole." To move closer to that goal, in this meeting the House adopted the following statements:

"After July 1, 1971, a new internship program shall be approved only when the application contains convincing evidence that the internship and the related residency years will be organized and conducted as a unified and coordinated whole.

"After July 1, 1975, no internship program will be approved which is not integrated with residency training to form a unified program of graduate medical education."

The House also adopted or approved essentials of approved programs in continuing medical education; essentials of an accredited educational program for histologic technicians; revision of essentials of approved internships and residencies pertaining to part-time appointments; essentials for approval of examining boards in medical specialties; revision of essentials of approved residencies in child psychiatry; revision of essentials of approved internships and residencies to add statement on employment relationship of house officers; revision of essentials of approved residencies in neurological surgery; revision of essentials of approved residencies in pathology; and revision of essentials of approved residencies in internal medicine.

A permanent Section on Neurological Surgery was created in the Scientific Assembly of the AMA.

Professional Liability: The House approved a Board report stating that liability insurance protection is essential so that physicians may continue to provide needed medical care to the public. "It has been concluded," the report said, "that the best way to provide such assurance is on a collective, rather than an individual basis, under programs jointly sponsored by the American Medical Association and the respective state medical association. . . . Minimum standards for an effective sponsored insurance program are being developed" and the Professional Liability Committee of the Board "is seeking with the insurance industry a means for instituting qualified insurance programs under such joint sponsorship with state associations which elect to participate."

Nurses and Other Allies: The following AMA position statement on nursing was adopted:

"The American Medical Association recognizes the need for, and will support efforts to increase, the number of nurses; recognizes the need for, and will facilitate the expansion of, the role of the nurse in providing patient care; encourages and supports all levels of nurse education; will promote and influence the development of a hospital nursing service, similar to a

medical care service, under the leadership of a chief of professional service, aimed at increased involvement in direct medical care of the patient; supports the concept of the physician-led health team; and will seek constructive collaboration with the total nursing community."

The House also resolved that "the American Medical Association undertake a thorough investigation of a method to bring allied professions into a collaborative relationship with the AMA such as the establishment of a new class of membership;" and "that consideration be given to preparing 'essentials' for those categories of the allied health personnel groups which do not have them, and that the opportunity for vertical and horizontal mobility be considered in determining these 'essentials.'"

Convention Sites and Dates: The 122nd Annual Convention of the AMA, originally scheduled for July, 1973 in New York, has been changed to June 24-28. It will be in New York.

The Clinical Convention of 1972, originally planned for Atlanta, will be held in Cincinnati, Ohio. The 1976 Clinical will meet in Philadelphia.

This is the line-up now:

	Annual	*Clinical*
1970	Chicago	Boston
1971	Atlantic City	New Orleans
1972	San Francisco	Cincinnati
1973	New York	Anaheim
1974	Chicago	Portland, Ore.
1976		Philadelphia

Drugs: The House took a number of important actions in connection with drugs. Among them:

That the AMA "encourage Committtees on Pharmacies and Therapeutics in each hospital to review drug reactions and related problems and to take appropriate control measures and to initiate informational programs."

That the AMA "seek passage of legislation for control of the manufacture and distribution of barbiturates and amphetamines."

That the AMA "expresses the concern of the medical profession that consumer protection be assured through more adequate surveillance of proprietary drug advertisements by private organizations and more effective cooperation in enforcement of applicable regulations by responsible governmental agencies."

That the AMA "supports dispensing by pharmacists of all medications in child-protective containers, and encourages acceptance of the containers by parents."

And that it is contrary to the public interest to repeal or modify "anti substitution laws and regulations in order to permit the filling of prescriptions with therapeutic agents not intended by the prescribing physician." The House declared its intention "vigorously to support the maintenance and enforcement of antisubstitution laws and regulations."

Hospitals: The House resolved that "the terms 'negative,' 'within normal limits,' and 'normal' be approved by the JCAH as acceptable designations for use in hospital charts."

It also resolved:

That the AMA request the JCAH to specify that a Joint Conference Committee "include, where feasible, adequate representation from community-based physicians elected by the medical staff."

That the AMA reaffirm its position that "general practitioners should have the opportunity to practice medicine as active staff members in hospitals and should be granted privileges commensurate with their training and demonstrated abilities."

And that the AMA suggest that "medical staffs consider revising their respective hospital medical constitutions and bylaws to differentiate clearly between medical and administrative duties."

Miscellaneous: The House supported the Board's plan to establish a wholly owned, separate subsidiary corporation to engage in publication and possibly other related activities now carried on by the AMA in order to gain various economies, lower costs and better administrative and accounting procedures.

Delegates adopted a Board proposal to undertake a "Communications Program for the 1970's," consisting of television documentaries, educational advertising, media relations and other related activities "to improve public understanding and opinion of the profession."

Approval was given to Report A of the Judicial Council, which said, among other things, that "It is not in itself unethical for a physician to own a for-profit hospital or interest therein. The use the physician makes of this ownership or interest may, however, be definitely unethical. For example, for a physician to send a patient to such a hospital or to prolong a patient's stay in the hospital for his financial benefit would be unethical."

The bylaws were amended to permit osteopaths in military service to become service members of the AMA.

The House resolved to "support continuing efforts by the American Medical Association to inform the medical profession of the value and benefit to be realized from the implementation of adequate peer review programs" and directed the Board, the Council on Medical Service and "other appropriate sections of the AMA" to give this project "the highest priority and emphasize its urgency to all state and component medical societies."

Mindful of its obligation to protect public health, the House called on each state society "to take whatever steps are necessary to inform state legislators about the health hazards posed by the cult of chiropractic." It also encouraged medical schools "to include specific information in their curricula regarding the nature of the health hazard to individuals . . . posed by quackery in general and the unscientific cult of chiropractic in particular."

The House directed the AMA to make a detailed and comprehensive study and analysis of the methods and requirements for reporting infant mortality statistics "by those nations that are alleged to have a lower rate of infant mortality than that of the United States."

Delegates resolved that the AMA continue its efforts "to alert the American people. . . to the ever increasing health hazards of environmental pollution and to the urgent need for expanded research and effective control measures;" and that the AMA "further extend and intensify its present activities in pollution control and improvement of environmental health."

Considering the plight of prisoners of war in North Vietnam, the House recommended that, "in the best medical interests of both servicemen and their families, the World Medical Association and/or other appropriate international organizations be requested to use their influence with those countries which do not subscribe to the Geneva Convention to the effect that (a) a list of prisoners' names be furnished, (b) inspection of prisoner compounds by neutrals be carried out, and (c) medical supplies and food parcels, as well as mail, be distributed to prisoners."

Awards: Charles B. Huggins, M.D., of the Pritzker School of Medicine, Chicago, was presented the Dr. Rodman E. and Thomas G. Sheen Award at the opening session of the House, along with the check for $10,000 which accompanies the award.

Special awards were presented to the stars, creator and producer of the ABC-TV program, "Marcus Welby, M.D." Robert Young (who portrays Dr. Welby); James Brolin (who plays the assistant, Dr. Kiley); David Victor, creator and executive producer; and David O'Connell, producer, all received plaques in front of the House. The program and the people responsible for it were cited for portraying "the human understanding and uncompromising care which physicians give to their patients."

Also honored at the opening session of the House were the AMA winners in the 21st International Science Fair, whose ex-

hibits were on display throughout the Scientific Assembly.

The winners were Beverly Fordham, a junior at Bryan Adams High school in Dallas: "Determination of Alpha Vigilance via Electroencephalography;" and Kevin Boran, senior at Lawton's Hill school in Pottsville, Pennsylvania: "Effects of Antidiuretic Hormone on Sweating Activity and Sweat Composition."

DON E. WOOD, M.D.
EUGENE F. SENSENY, M.D.
FRANK H. GREEN, M.D.
JACK E. SHIELDS, M.D.
JOHN FARQUHAR, M.D.

Supplemental Report, Chairman AMA Delegation

The report is detailed in the Handbook, so I won't bore you with any details. I would like to mention a few issues that were of some concern to us and should be of some concern to the House here today and tomorrow. One of the important actions that was taken involved the liberalization of the stand the AMA House of Delegates took on abortion, which is well detailed in the Handbook. I think another gut issue is the dues increase of $40.00. Now it was the understanding when we left this meeting that the substantiation of the dues increase would be spelled out to the membership through the component societies as well as through the state societies. I bring this to your attention because I think this should legitimately be the business of the House to be either voted up or voted down. One of the reasons I asked for just a niekel's worth of time was that I wanted to have all of you to have the opportunity to see the members of the AMA delegation, delegates and alternates, people who represent you down there. To give you some idea of some of the muscle that we have, I would like, Mr. President, at this time, with your permission, to have the opportunity to introduce the other members of the delegation. (AMA delegates and alternates delegates introduced.) In addition to this, there are three other men that represent sections and they have been very important to us. I think the old pro of the whole group is Lall Montgomery, who has been invaluable to the delegation; Dr. Myron Nourse is the alternate delegate from the Section on Urology and Dr. Sprague Gardiner, who is now the delegate from the Section on Obstetrics and Gynecology. It has been a pleasure to represent you people. I think we have done a reasonable job and I think the House of Delegates and ISMA can be basically proud of the delegates, alternates and section delegates.

Report of Board of Medical Registration and Examination of Indiana (July 1, 1969 to June 30, 1970)

HOUSE ACTION: Ordered filed.

Applications received for June 1970 state board examination (medicine)	643
Ineligible to take state board examination for various reasons	101
Approved for 1970 state board examination	542
Failed to appear for state board examination	77
Applicants taking state board examination	465
Candidates failed the state board examination	110
Candidates from I. U. Medical School taking state board examination	206
Candidates from I.U. Medical School taking state board and failed	1
Candidates taking Doctor of Osteopathy examination	1
Candidates taking Doctor of Osteopathy examination, failed	0
Candidates from foreign medical and other schools taking state board examination	259
Candidates from foreign medical and other schools, failed	109
Over-all failure rate	23.6
I.U.M.C. graduate, failure rate	.48
Foreign medical school graduate, failure rate	42
Candidates taking chiropractic state board examination	0
Candidates taking physical therapy examination	23
Candidates taking physical therapy examination, failed	0
Candidates taking podiatry state board examination	0
Candidates taking podiatry national board examination, licensed	11
Candidates, podiatry, failed	0

Totals, Licensed by Examination

	1967-1968	1968-1969	1969-1970
Medicine	330	257	355
Physical Therapy	29	31	23
Podiatry	3	4	11
Osteopathy	0	0	1
Chiropractic	0	0	0

	1967-1968	1968-1969	1969-1970
Applicants granted license in Indiana by endorsement/reciprocity (M.D.)	163	135	181
Applicants endorsed to other states (M.D.)	342	315	309
Applicants granted license in Indiana by endorsement/reciprocity (osteopathy)	10	11	10
Applicants endorsed to other states (osteopathy)	0	2	2
Applicants granted physical therapy license in Indiana by endorsement/reciprocity	21	30	22
Physical therapists endorsed to other states	1	7	7
Applicants granted chiropractic license in Indiana by endorsement/reciprocity	14	13	13
Chiropractors endorsed to other states	0	0	0
Applicants granted podiatry license in Indiana by endorsement/reciprocity		3	2
Podiatrist endorsed to other states		1	0
Citations or board action during the year (all groups)		12	12
Revocations during the year (all groups)	2	0	4
Licenses reinstated		2	2	1
Physicians, voluntarily surrendering their narcotic stamp to the Internal Revenue Dept.	6	6	4

TOTALS, BOARD LICENSURE:

8,025 (M.D.) (resident and non-resident)	7,165	7,655	8,025
276 (D.O.) (resident and non-resident)	271	279	276
139 (drugless) (resident and non-resident)	205	180	139
338 (chiropractor) (resident and non-resident)	369	343	338
356 (physical therapy)	292	316	356
189 (podiatry)	203	198	189
3 (midwife)	2	2	3
Temporary physical therapy permits issued	5	7	7
Temporary medical permits issued	37	56	70
Internship permits issued	164	156	158
Temporary medical educational permits issued	54	50	50
Temporary physicians permits issued		32	13
Medical teaching permits issued		9	9
Medical corporations licensed in Indiana		121	207

1969-1970

FINANCIAL STATEMENT

Medical	$81,205.00
Chiropractic	2,180.00
Podiatry	555.00
Physical therapy	3,359.00
Total Revenue to June 30, 1970	$87,294.00
.1 Personal services	41,810.17
.2 Services other than personal	2,918.95
.3 Services by contract	27,983.46
.4 Materials, supplies and parts	345.94
.5 Equipment	331.33
.8 In-state travel	5,079.88
.9 Out-of-state travel	282.88
Total Disbursements	$78,752.61

Maternal Mortality Study Committee

HOUSE ACTION: Ordered filed.

Reports of Standing Committees and Commissions

Executive Committee

HOUSE ACTION: Accepted.

The Executive Committee has met regularly throughout the year, usually with a full attendance of all members. In this report I will not attempt to go into great detail as to the activities of the committee inasmuch as the minutes have been published regularly in *The Journal* and widely distributed. Also copies of all minutes are in the hands of the Reference Committee for their review.

However, in addition to the usual housekeeping responsibilities of the committee, I would like to call attention to just a few of the transactions handled by your Executive Committee during the past year.

A letter from the State Department of Public Welfare concerning implementation of Title XIX was referred to the Board of Trustees.

Approved a joint meeting of the executive committees of ISMA and the Indiana Hospital Association.

Discussed the plans for the "Teen Health Week" program and this was referred to the Board of Trustees for their consideration.

At the request of the Governor, made suggestions for appointments to the Day Care Committee; the Civil Defense Committee and the Board of Medical Registration and Examination.

Approved the recommendation of the Commission on Medical Education and Licensure that service certificates be prepared for participants in the Preceptor Program.

Met with the president of the Woman's Auxiliary of ISMA to discuss program and planning for the coming year.

Approved the budget for the 1970 fiscal year and referred same to the Board of Trustees for their approval.

Recommended certain changes in the budgeting as recommended by the George S. Olive Company, auditors.

Referred to the Board of Trustees a request from the county societies that Blue Shield prepare reports on a county basis of the usual and customary charges.

Referred to the AMA Legal Department many questions concerning the legality of certain provisions in the Medicaid program.

Reviewed the mandatory orientation program.

Agreed to present the name of Dr. James O. Ritchey for the Sheen Award.

Referred to the Board of Trustees a request from Blue Cross-Blue Shield for an increase in rates for the physicians' group.

Received a report from the executive secretary that the CHAMPUS program was now exceeding a million dollars per year.

Referred to the Board of Trustees a suggestion that the ISMA extend an official invitation to the AMA to hold its 1975 Clinical Session in Indianapolis.

Approved the request of the Indiana Chapter of SAMA to hold meetings in the headquarters building.

Reviewed the actions of the National Association of Blue Shield Plans.

Made recommendations for appointment of members to the Indiana Advisory Hospital and Health Facility Planning Council.

Approved a program of the Cerebral Palsy of Indiana to conduct an additional program on Rubella vaccine.

Referred to the Commission on Medical Economics and Insurance the suggestion of J. Russell Townsend that the income limits of the ISMA Disability program be increased to $1,000.

Report from G. O. Larson, M.D., president of the Indiana State Advisory Comprehensive Health Planning Council, was given.

Approved the submission of a resolution from Dr. Jack Hickman for possible presentation to the AMA requesting a decrease in the number of approved residencies.

Authorized the president to sign a new contract between ISMA and the OCHAMPUS program.

Referred to the Board Committee on Fiscal Matters the requirement of the Federal government that the employees' retirement plan of the association be changed by January 1, 1971.

Authorized the appointment of a special committee to discuss naming some of the rooms in the headquarters building as memorials to individuals.

Received a report that a Section on College Medicine had been formed.

Received several reports from individuals and county societies expressing their opinion on the Himler Report.

Received letters from several Indiana congressmen concerning the association's letter voicing objection to the Senate Finance Committee report inferring that five physicians from Indiana were guilty of receiving more than $25,000 under the Title XIX program.

Reviewed proposed advertising by the National Blue Shield Plan and voiced objection to the copy content.

Received opinions from legal counsel on several matters.

Received a report that the anesthesiologists of Indiana were using the American Society of Anesthesiologists Relative Value Guide.

Reviewed the MECO project and information from the Illinois State Medical Society regarding this program and referred the information to the Commission on Medical Education and Licensure.

Ordered the distribution of comments on the Himler Report made by an English physician currently in practice in Indiana.

Heard a report from the president concerning conferences he and the executive secretary had had with the oficials in the Department of HEW concerning the Senate Finance Committee report.

Approved a suggestion of the executive secretary that the State Department of Welfare be informed that there was no reason for doctors to be required to sign a Civil Rights and Fraud Statement on claims under Title XVIII and Title XIX inasmuch as members of the association subscribe to the Principles of Medical Ethics which provided this protection.

Formulated a proposal to RMP for expansion of joint field service under ISMA direction for Indiana State Medical Association and RMP.

Reviewed an exchange of correspondence between the headquarters office and the Secretary of Defense concerning release of information on physicians and medical corpsmen who are being discharged from the military service.

Received reports from representatives to the National Conference on Voluntary Health Agencies and the Regional Meeting on Medicine and Religion.

Reviewed copies of letters concerning Procter and Gamble sponsorship of CBS programs on health.

Received a proposed bill concerning letting down the bars for licensing of foreign physicians. This was referred to the Board of Trustees.

Recommended to the Board of Trustees that the association oppose a proposed bill on the Workman's Compensation.

Reviewed plans for the facilities of the 1970 annual meeting in South Bend.

Approved the Indiana Chapter of Society of Internal Medicine moving their office into the headquarters office of the association.

Referred to the Board of Trustees a proposal for membership in the Indiana Traffic Safety Council.

Heartily recommended the efforts of Dr. Charles A. Bonsett on the formation of the Indiana Medical History Foundation to turn the old Pathology building located at Central State Hospital into a medical museum.

Referred to the Board of Trustees a recommendation for legislation made by the Commission on Public Health.

Referred to the Board of Trustees a letter from the Woman's Auxiliary concerning the ISMA collecting dues for the state auxiliary.

Received a report from Judge Hamill concerning the settlement of the suit between the Indiana State Medical Association and Blue Cross which will prohibit Blue Cross from furnishing professional services.

In addition, at each meeting, the Executive Committee reviewed the financial status of the association, as reported by the treasurer, as well as the membership report and suits filed against physicians for malpractice.

Your Executive Committee has had a busy year with meetings consuming from six to eight hours of time.

Medical Defense Activities

1. *Malpractice Cases.* A year ago, at the time of this report, August 1, 1969, the following four cases were pending before the committee:

Case 307—Suit filed March 22, 1962. Pending. (Expense to date, $1,042.73.)

Case 309—Suit filed December 10, 1964. Pending.

Case 312—Suit filed December 7, 1965. (Case closed April 1, 1970. Expense for attorney's fee $4,314.12.)

Case 313—Suit filed September 5, 1967. Pending.

Since August 1, 1969, and up to August 1, 1970, one new case has been filed.

2. *Medical Defense Fund Statement from August 1, 1969 to August 1, 1970:*

Bank Balance, August 1, 1969	$ 5,264.46
Receipts	9,968.61
Total Cash and Receipts August 1, 1970	$15,233.07
Disbursements:	9,592.65
Balance on hand August 1, 1970	$ 5,640.42

The Journal

The financing problems of *The Journal* remain one of our biggest headaches. What we have gained in reduction of production costs has been offset in the drop in revenue from advertising. The advertising continues to fluctuate and at the rate we are going for 1970, the income from advertising may be one of the lowest in years. Despite the financial situation, it does not seem prudent to lower the standards of *The Journal*, which is recognized as one of the best state journals published.

Listed below is a comparative report of *The Journal* operations over the past several years and the first six months of 1970.

The following table shows the number of journal pages for the past six years (includes inserts).

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. Pages per Issue
1964	1051	71	423	29	1474	123
1965	998	68	464	32	1462	122
1966	789	50	781	50	1570	131
1967	1041	58	751	42	1792	149
1968	1068	61	696	39	1764	147
1969	1041	67	509	33	1550	129

The table below shows the total printing costs of *The Journal:*

Year	Total Printing Cost	No. of Pages (Inserts excluded)
1965	$35,957.50	1416
1966	$41,795.32	1410
1967	$49,958.15	1450
1968	$50,709.62	1463
1969	$42,916.62	1312
(6 months)	$21,751.16	648

A comparison of advertising revenues for the first six months of the last four years, with a like figure for 1970 is as follows:

State Medical Journal Bureau	1966	1967	1968	1969	1970
	$18,069.54	23,468.96	24,153.24	17,086.59	15,791.12
Sold Direct by Journal	1966	1967	1968	1969	1970
	2,687.76	3,056.68	7,200.10	2,557.80	2,268.80
Total	1966	1967	1968	1969	1970
	$20,757.30	$26,525.64	$31,353.34	$19,644.39	$18,059.92

MEMBERSHIP REPORT

	December 31, 1969	July 31, 1969	July 31, 1970	AMA, July 31, 1970
1st District				
Gibson	13	13	12	12
Perry	7	7	8	8
Pike	3	3	3	3
Posey	7	7	7	7
Spencer	4	4	3	3
Vanderburgh	235	233	239	237
Warrick	6	6	7	7
TOTAL	275	273	279	277
2nd District				
Daviess-Martin	20	20	19	16
Greene	14	14	14	10
Knox	38	38	37	36
Owen-Monroe	84	84	83	78
Sullivan	13	13	13	12
TOTAL	169	169	166	152
3rd District				
Clark	47	47	47	46
Dubois	24	24	25	23
Floyd	41	41	44	41
Harrison-Crawford	10	10	9	9
Lawrence	25	25	27	24
Orange	9	9	8	8
Scott	5	5	6	6
Washington	10	10	7	7
TOTAL	171	171	173	164
4th District				
Bartholomew-Brown	50	50	55	51
Dearborn-Ohio	17	16	15	15
Decatur	11	11	11	10
Jackson-Jennings	23	23	23	23
Jefferson-Switzerland	31	31	28	27
Ripley	10	10	8	7
TOTAL	142	141	140	133
5th District				
Clay	15	15	13	13
Parke-Vermillion	16	16	17	17
Putnam	18	18	19	19
Vigo	116	115	119	118
TOTAL	165	164	168	167
6th District				
Fayette-Franklin	14	14	16	16
Hancock	23	23	26	26
Henry	35	35	39	37
Rush	12	12	12	12
Shelby	19	19	20	18
Wayne-Union	74	74	74	72
TOTAL	177	177	187	181

7th District				
Hendricks	20	20	20	20
Johnson	34	34	33	31
Marion	1072	1062	1056	1054
Morgan	18	18	19	18
TOTAL	1144	1134	1128	1123
8th District				
Delaware-Blackford	120	116	121	118
Jay	16	16	16	11
Madison	109	107	106	76
Randolph	18	18	17	13
TOTAL	263	257	260	218
9th District				
Benton	9	9	9	9
Boone	21	20	19	17
Clinton	15	15	14	14
Fountain-Warren	11	11	11	11
Hamilton	18	18	16	15
Montgomery	24	24	22	22
Newton	5	5	5	5
Tippecanoe	140	140	141	134
Tipton	11	11	11	11
White	8	8	7	7
TOTAL	262	261	255	245
10th District				
Jasper-Newton	7	7	7	7
Lake	454	452	453	423
Porter	52	52	51	50
TOTAL	513	511	511	480
11th District				
Carroll	9	9	7	7
Cass	33	33	36	33
Grant	71	71	71	71
Howard	68	68	65	65
Huntington	19	19	19	19
Miami	14	14	15	14
Wabash	29	29	33	30
TOTAL	243	243	246	239
12th District				
Adams	14	14	13	13
Allen	310	307	314	301
De Kalb	23	23	23	23
LaGrange	8	8	10	9
Noble	14	14	12	12
Steuben	12	12	11	11
Wells	47	47	46	46
Whitley	17	17	16	15
TOTAL	445	442	445	430
13th District				
Elkhart	114	114	114	110
Fulton	9	9	9	9
Kosciusko	17	16	13	13
La Porte	96	96	94	86
Marshall	26	26	25	25
Pulaski	5	5	5	2
St. Joseph	240	235	232	231
Starke	6	6	7	7
TOTAL	513	507	499	482
SUMMARY				
1st District	275	273	279	277
2nd District	169	169	166	152
3rd District	171	171	173	164
4th District	142	141	140	133
5th District	165	164	168	167
6th District	177	177	187	181
7th District	1144	1134	1128	1123
8th District	263	257	260	218
9th District	262	261	255	245
10th District	513	511	511	480
11th District	243	243	246	239
12th District	445	442	445	430
13th District	513	507	499	482
TOTAL	4482	4450	4457	4291

DONALD M. KERR, M.D.,
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LOWELL H. STEEN, M.D.
MALCOLM O. SCAMAHORN, M.D.
PETER R. PETRICH, M.D.
LESTER H. HOYT, M.D.
HUGH K. THATCHER, M.D.

Grievance Committee

HOUSE ACTION: Referred to Board of Trustees for action.

The Grievance Committee held meetings on April 19 and July 12, 1970.

As of August 1, 1970, 16 cases were considered during the year. Eight new cases were filed during the year. All cases except four have been closed.

The ISMA Grievance Committee continued to follow the procedure of recent years. (1) Receipt of complaint is acknowledged by a letter which states that action can proceed only after receiving the complainant's permission to forward a full copy of the complaint to the physician or physicians named therein, along with identification of those filing the complaint; (2) Should the requested permission be received, the physician named is asked to attempt a personal settlement of the complaint; (3) Should the physician be unsuccessful or should he request that his county medical society attempt settlement, the matter is so referred with the ISMA Grievance Committee retaining responsibility as the rules governing it require. It is the recommendation of the ISMA Grievance Committee that a greater attempt be made at the local level to settle differences before the state committee is involved.

It is important in maintaining effective function of the ISMA Grievance Committee that all county society grievance committees and county society secretaries abide by the 1962 House of Delegates directive in reporting disciplinary action taken at the local level.

The 1967 House of Delegates directed that the publication *Purposes, Rules and Procedure of the Board of Appeals on Patient-Physician Relations* (The Grievance Committee) approved by the Council on April 26, 1952, be brought up to date. This matter has not been completed and it is the recommendation of the ISMA Grievance Committee that the publication be brought up to date.

The Grievance Committee wishes to thank the members of ISMA who have been called upon to assist in discharging its responsibility. We have received excellent help.

WALLACE R. VANDENBOSCH, M.D.,
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Vice-Chairman
ROBERT G. YOUNG, M.D.,
Secretary
KENNETH L. OLSON, M.D.
EARL W. MERICLE, M.D.
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JOHN M. PARIS, M.D.
WILSON L. DALTON, M.D.
WILLIAM R. NOE, M.D.
HUGH K. THATCHER, JR., M.D.

Student Loan Committee

HOUSE ACTION: Referred to the Board of Trustees for the purpose of re-evaluation of the program and report back to the 1971 House of Delegates.

The Student Loan Committee held four meetings during the past year. The committee interviewed 10 students and loans were granted to nine applicants for a total of $8,700.00; one applicant received a loan from another source.

Under the Guaranteed Loan Plan with the Indiana National Bank, which was instituted December 1, 1963, the association has on deposit with the bank $20,810.00 to guarantee loans totaling $260,000.00. As of July 31, 1970, 105 loans, totaling $92,500.00, have been granted under this plan. Forty-one loans have been converted to installment loans in the amount of $37,960.10. To date there have been two defaults—one in the amount of $606.54 and the other in the amount of $1,913.00. The Indiana National Bank has been reimbursed for these two loans from the Student Loan Fund. On July 10, 1970 a suit was filed in Municipal Court of Marion County against the physician who owes the association $606.54 plus interest.

A report on the Loan Fund which was under the association management from October, 1955, to December 31, 1963, follows:

Total loaned to 117 students	$58,458.36
Total repaid by loanees as of July 31, 1970	$57,646.32
Total amount outstanding, July 31, 1970	$ 812.04

Of the 117 who received loans,
113 have repaid in full
*4 are making payments

*Total due on above 4 loans still outstanding	$ 812.04

All delinquent accounts have been collected.

The Student Loan Fund does provide an essential service to students in need of financial help and it is the recommendation of the Student Loan Committee that this

type of loan procedure should be continued.

LESTER D. BIBLER, M.D., *Chairman*
JAMES O. RITCHEY, M.D., *Vice-Chairman*
JOE DUKES, M.D., *Secretary*
LOWELL H. STEEN, M.D.
LESTER H. HOYT, M.D.
GLENN W. IRWIN, M.D.

Future Planning Committee

HOUSE ACTION: Approved first 5 paragraphs, balance of report accepted for information.

Doctor Rifner brought us up-to-date regarding AMA's attitude and plans on the "Himler Report." He reported a new, permanent Future Planning Committee of AMA has been organized. Its membership is staggered and rotating. Of the nine members, four are appointed by the speaker of the house of delegates (two being delegates and two at large); four are appointed by the board of trustees (two being trustees and two at large), and one is appointed by SAMA.

This Future Planning Committee should have a "blue sky" function, particularly in the areas of (1) the effective restructuring and functioning of ISMA, (2) the delivery of health care systems, and (3) educational programs needed to produce the health care planned in No. 2.

Minutes of meetings of all other committees should be distributed to the chairman of the Future Planning Committee so that this committee doesn't spend time "blue skying" something that is already being planned or implemented by another committee.

The Future Planning Committee should be anticipating the future—not waiting for crises. They should talk with organizations and individuals interested and involved in health care delivery such as labor unions, insurance companies, and the ISMA executive secretary for knowledge of their needs, plans and expectations.

We should resubmit some of our 1969 resolutions. We should include those dealing with mail ballot voting for ISMA officials and the 30% yes vote of membership represented to make an election valid. We should exclude those that deal with length of term of office.

We wish to propose a resolution affecting the annual conventions starting in 1971. We propose that ISMA sponsor no scientific programs. All programs will be dealing with business, economics, public relations, politics or social events. We should invite the state specialty organizations (including the Academy of General Practice) to offer any scientific programs they wish in conjunction with the annual meeting of ISMA. When any specialty organization wishes to affiliate with ISMA, its officers should replace ISMA specialty section officers and the specialty section as such be phased out.

We would again encourage ISMA to invite specialty organizations to affiliate with ISMA using ISMA's administration facilities and personnel.

ISMA must be a consensus—not a majority rule organization. Organized medicine needs to find points in common. We must represent most, if not all, physicians or lose our strength. Policies which are divisive and cannot accommodate a variety of opinions weaken any influence we can exert on the future of health care delivery.

G. O. LARSON, M.D., *Chairman*
ED TYLER, M.D., *Vice-Chairman*
MAURICE E. GLOCK, M.D.
JAMES FITZPATRICK, M.D.
A. W. RATCLIFFE, M.D.
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CHARLES F. GILLESPIE, M.D.
LESLIE BAKER, M.D.
RALPH V. EVERLY, M.D.
LOWELL H. STEEN, M.D. (*ex-officio*)
MALCOLM O. SCAMAHORN, M.D. (*ex-officio*)
PETER R. PETRICH, M.D. (*ex-officio*)
DONALD M. KERR, M.D. (*ex-officio*)
FRANK B. RAMSEY, M.D. (*ex-officio*)

Committee on Medicine and Religion

HOUSE ACTION: Filed for information and to be circulated to membership.

Why is the Committee on Medicine and Religion trying to urge doctors and clergy to get together? Why not a committee of doctors and dentists, or lawyers? After all, our patients have problems in those fields, as well as religion. Why should a doctor send a patient to a minister? For the same reason a minister sends his parishioner to a doctor when the parishioner gets sick with a physical illness.

When our patients "come apart" at the threat of death or need a stabilizing friend, they could use a minister's help. Do you have a patient who is too sensitive about guilt? How about sending him to a specialist on guilt—a minister, a rabbi, or a priest?

"But I know a minister who is a poor one to be seeing my patients if they are guilty. This fellow would make anyone feel like he's doomed for hell." O.K., so some ministers don't handle guilt very well with parishioners; how about sending the patient to another minister who does know how to advise on guilt without causing problems? Where would one find such a clergyman?

The Committee on Medicine and Religion is trying to promote getting together doctors and ministers just to see what mutual problems can be worked out. Why not try making a simple conversation with a minister over a cup of coffee or over the telephone? There are many ministers in your area who could help your patients. Make it easy on yourself; know the ministers in your town. Perhaps one of them can ease your patient's problem of finding himself sometime.

B. E. KINTNER, M.D., *Chairman*
JOHN C. SLAUGHTER, JR., M.D.
DONALD E. WOOD, M.D.
JOHN E. READ, M.D.
EDWIN B. BAILEY, M.D.
HUNTER SOPER, M.D.

Convention Arrangements

HOUSE ACTION: The scientific program and exhibits constitute the report of this commission and recommends approval.

Commission on Constitution and Bylaws

HOUSE ACTION: The following amendments to the Constitution were introduced and approved but will lay over until the 1971 meeting before final action is taken.

Constitutional Changes

The following changes in the Constitution are presented at this time but final action cannot be taken until the 1971 meeting under provisions for amending the Constitution contained in Article XIV of the Constitution.

Be It Resolved that Article VI of the Constitution be amended by deleting the last sentence of the Article which reads "seven Trustees shall constitute a quorum" and insert in lieu thereof "A majority of elected Trustees shall constitute a quorum."

Be It Resolved that the present Section 3 of Article VIII be deleted and the following be inserted in lieu thereof: "Section 3.—Special meetings of either the Associa-

tion or the House of Delegates shall be called by the President upon receipt of a petition signed by 30 delegates or 100 members. The signed petition shall contain the names of at least ten delegates or 34 members from each of at least three Board districts. Upon receipt by the President of such a petition, the President shall within 30 days thereafter issue a call for such special meeting at a time and place to be fixed by the President. The President, in specifying the time of such special meeting, shall fix the same as soon thereafter as reasonable and suitable arrangements can be made."

Be It Resolved that Article IX, Section 1 be amended by striking the word "thirteen" and inserting in lieu thereof the word "the" which will then make Section 1 read as follows: "Section 1.—The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, an Assistant Treasurer and the Trustees, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member."

Be It Resolved that Article IX, Section 4 be amended by striking the word "Trustee" in the first sentence and inserting in lieu thereof the following: "Trustee (s)" or "alternate Trustee(s)" which will make Section 4 then read as follows: "Section 4—The Trustees shall be elected by the respective district societies. If any district fails to meet and elect its Trustee (s) or alternate Trustee(s) by the time of the expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election."

Be It Resolved that Article IX, Section 5 be amended by striking the word "an" in the first sentence and adding after the word Trustee "(s)" which will make Section 5 then read as follows: "Section 5. Each Trustee district shall elect alternate Trustee(s) whose term of office shall be the same as the Trustee, namely three years. The alternate Trustee shall be elected in a year during which there is no Trustee elected.

"The duties of the alternate Trustee shall be:

"1. To represent the Trustee district in the absence of the regularly elected Trustee.

"2. To vote only in the absence of the regularly elected Trustee either in the House of Delegates or in Board meetings where he represents the regularly elected Trustee."

Bylaws

HOUSE ACTION: The following amendments to the Bylaws were adopted.

Be It Resolved that Chapter I, Section 1 be deleted in its entirety and present Section 2 be renumbered Section 1; present Section 3 be renumbered Section 2; present Section 4 be renumbered Section 3; and present Section 5 be renumbered Section 4.

Be It Resolved that Chapter II be amended by adding a new section as follows: "Section 5—Any of the component member county societies wishing to invite the Indiana State Medical Association to hold its annual meeting in its locality shall submit an invitation in writing at least five years in advance to the Board of Trustees. The Board of Trustees shall make an investigation of the facilities and in turn recommend the location of the annual meetings for concurrence by the House."

Be It Resolved that Chapter IV, Section 2 be amended by adding the following sentence at the end of the first paragraph "Two delegates are to be selected by the Indiana Chapter Student American Medical Association who shall be seated though without power of vote."

Be It Resolved that Chapter XXIX, Section 2 be amended as follows: By adding a new sentence, at the end of the first paragraph, which reads as follows: "At least one of which shall be organized for the sole purpose of studying the addresses of the President; President-elect; report of the Executive Secretary; and chairman of the Board of Trustees. This committee shall be mandated to translate recommendations made by these officers through resolutions for presentation to the House. . .", the balance of the section to remain the same.

Be It Resolved that Chapter XXXI, Section 4 be amended as follows: "Wherever the word trustee appears there shall be added an "(s)" and the word "a" preceding the first Trustee shall be deleted which will then make the Section read as follows: "Section 4—Each district society shall organize by electing a president, a secretary, and a treasurer and Trustee (s) and alternate Trustee(s) as the current Trustee(s) term and alternate Trustee(s) term for the district expires, and such others as may be provided for in its Constitution and Bylaws. The office of secretary and treasurer may be held by the same physician. The Trustee(s) shall continue to have the same duties and terms as are set forth in the Constitution and Bylaws of this Association."

Be It Resolved that Chapter XXXI be amended by adding a new section to read as follows: "Section 5.—Each district society shall have one Trustee and one alternate Trustee for each 600 active members or major fraction thereof but in any event each district shall have one Trustee and one alternate Trustee. The term of each trusteeship newly created by the numerical growth of a district shall begin at the organization meeting of the Board immediately following the adjournment of the second meeting of the House of Delegates at the next annual meeting, in accordance with Chapter VII, Section 1."

Be It Resolved that Chapter XXXI, present Section 5 be renumbered Section 6; the present Section 6 be renumbered Section 7; the present Section 7 be renumbered Section 8; the present Section 8 be renumbered Section 9; and the present Section 9 be renumbered Section 10.

GORDON S. FESSLER, M.D.,
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EUGENE W. AUSTIN, M.D.
PAUL ARBOGAST, M.D.
JOSEPH F. FERRARA, M.D.
GEORGE YOUNG, M.D.
CHARLES PLANK, M.D.

Legislation

HOUSE ACTION: Filed for information.

The Commission on Legislation met several times throughout the year on this off-year for our State Legislature.

We discussed current national congressional legislation. In addtiion, we basically followed the philosophy of the AMA and their suggestions based on their Washington office's assay of various bills.

The major prediction is, of course, a national compulsory health insurance program for coverage of all the people in the United States; the inside political analysts tell us this bill is not five or ten years away but only two or three years. Organized medicine—both local, state and national—will have to take a stand on this issue.

As concerns our biennium which meets in January of 1971, we will have great concern with bills to be introduced that affect the public health and welfare as

well as physicians collectively and individually.

To enumerate a few:

1. A change in the law concerning foreign medical graduates and their ability to obtain a license in Indiana.
2. Reporting by laboratories of findings concerning VD to the Indiana State Board of Health.
3. Authority for local boards of health to obtain legal counsel above and beyond that now provided to help implement new ordinances and develop new ones.
4. Possible changes in Medicaid or Title 19.
5. An act concerning provision and regulation of emergency medical services, describing the powers and duties of the State Board of Health related thereto and making an appropriation therefor.

These are but a few of the items that we must be concerned with.

As chairman during this off-year and because my tenure has expired on the commission, I want to personally thank all the members of this commission for their loyalty and dedication to duty.

The ISMA can be proud of the record of this most important commission down through the years.

EUGENE F. SENSENY, M.D., *Chairman*
JOHN DAVIS, M.D., *Vice-Chairman*
ROBERT E. ARENDELL, M.D.
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JOSEPH C. FINNERAN, M.D.
JACK L. ALEXANDER, M.D.
MAX N. HOFFMAN, M.D.
E. L. C. BROOMES, M.D.
LESTER RENBARGER, M.D.
JOHN E. ARFORD, M.D.
JACK W. HICKMAN, M.D.
DON E. WOOD, M.D.

Public Information

HOUSE ACTION: Ordered filed.

The Commission considered many problems during the course of the past year dealing with public relations and public information. Following is a summary of these considerations and recommendations:

Teachers Kit on Quackery—These kits were ordered by the Commission and distributed to teachers throughout the state through the School Health Conferences which are conducted annually by the Indiana State Board of Health and other agencies involved in the Indiana educational process.

Today's Health—*The Commission recommends* that this publication be available to all public schools in Indiana and that it should be the responsibility of county medical societies to see that it be provided to their school systems with appropriate announcements of this activity in the local press.

Biographical Survey of Physicians—*The Commission recommends* that a new biographical survey be made of the membership of the Association to update current information and to include in this survey questions as to their participation in community affairs and organizations. Approximate cost—$1500.00. Such participation could be the source of news stories for the state's press with emphasis on the concern of physicians in a variety of areas other than health related matters.

Distribution of Voluntary Health Agency Placards—Dr. Norman Booher, chairman of the Commission on Voluntary Health Agencies, appeared before the Commission seeking assistance for a broader distribution of information to the public concerning the state agencies approved by the Commission as operating within the framework of the standards set forth by the Commission and the ISMA. The Commission recommended that the placard be distributed annually to all physicians and further that a letter be sent by the president of ISMA to physician members suggesting that the placard be displayed to public view and setting forth the reasons for the presentation of the certificate.

The Commission further endorsed the transmission of a letter to the Board of Trustees and the Executive Committee of the Association requesting a review of the previous attorney's decision limiting the distribution of the certificates, and further requesting that the Board of Trustees consider the feasibility of distributing this certificate to labor groups, Chambers of Commerce, Better Business Bureaus and similar community agencies.

The Board of Trustees of the Association subsequently endorsed these recommendations and the Headquarters Office is now in the process of making these distributions.

Annual Meeting of the Indiana Public Health Association—Dr. Booher further informed the Commission of the poor physician attendance at this meeting. Annually the Commission participates in a half-day segment of the meeting and is responsible for obtaining speakers and selecting subject matter. This particular meeting portion is always physician-interest oriented, but it does serve as an adjunct in telling a broad segment of individuals involved in the state's health problems of the activities of organized medicine and individual physicians in a number of areas. Speakers for this segment have been outstanding.

The Commission on Public Information subsequently recommended that, annually, all physicians receive copies of the program of the Indiana Public Health Association annual meeting, that the distribution and expense be borne by the ISMA and that additional emphasis be given to the program through the Newsflash and letters to county medical society officers.

Full-Time Public Relations Personnel—The Commission considered the need for full-time public relations personnel. Mr. John Newland, director, Indiana University News Bureau, met with the Commission and discussed the matter and cited expenditures on the employement of an agency or an individual which would require expenditures from $3,000 to $18,000 per year. The advantage of a full-time public relations person is that his services are always at the disposal of both state and county societies, while an agency person may not be immediately available. However, it was pointed out that there is a great need for internal public relations efforts designed to motivate the physician to accept his personal responsibility for community public relations.

The Commission recommends that a full-time public relations person be added to the staff of ISMA and that the matter deserves continuing concern and study as well as very prompt action.

Hoosier Teen Health Happening—As a follow-up to this program which attracted over 3,000 high school students throughout Indiana, audio tapes of the discussions are being enthusiastically utilized in health classes and by other youth organizations. In addition, 16 mm black and white films on each segment of the program will be available for use by the middle of September and will be so promoted and publicized by the Association.

The Commission additionally feels there is a need for local physician participation and continuing effort at the community level in all of the aspects of sex, alcohol and drugs, which were major subjects discussed at the Happening.

The Commission suggests that worthwhile subjects for future conferences are ecology, emergency medical services and health careers.

Indiana Health Careers—Doctor Mary B. Backer represents the ISMA with this group which represents 42 organizations active in the field of health and health education. Health Careers is now a

part of RMP and receives financial support, in part, from this program. The advent of such support has made it possible for them to have adequate secretarial, executive, and field help so that the functions of the Health Careers, Inc. can be more effective. It was pointed out that this organization now involves representatives of all the professional health organizations, the voluntary health organizations and organizations in various allied and technical health fields. Included also is the Indiana Hospital Association and various organizations of educators at the high school as well as the university level. It was pointed out by Doctor Backer that this group could well serve as a coordinating and action group for future programs, particularly those involved in discussions and presentations of health careers.

The need for an official liaison status between the Board of Trustees and Health Careers, Inc. was discussed and it was suggested that the reports of the actions of Indiana Health Careers be made a part of this Commission's report and that the ISMA liaison representative make a direct personal contact with the Chairman of the Board of Trustees and the President of the Association to keep them informed.

Community Service Award and Journalism Award—The commission circulated application forms to all county medical societies concerning these awards. Applications were reviewed in midsummer for the Community Service Award and a judgment made concerning the recipient, who will receive the award during the annual convention of the Association in South Bend in October. No journalism award applications were received.

In addition, the Headquarters Staff, which served as an arm of assistance to all commissions, completed the following in the general area of public information. Though the list is incomplete, it will give an idea of the broad scope of activity in the area of public information.

1. Prepared a staff summary of public relations evaluation and needs.
2. Provided materials to students on health careers and medical careers.
3. Provided kits of materials to high school classes as follow-up to Hoosier Teen Health Happening.
4. Provided materials to students at all levels for research papers on a variety of medically oriented subjects and medical organizational structure.
5. Handled all promotion for the Hoosier Teen Health Happening through all state media and state and national publications.
6. Provided press room facilities at Happening and assisted reporters in on-the-scene coverage.
7. Accomplished same with the Annual Convention of ISMA.
8. Arranged for television interviews in Headquarters dealing specifically with Medicaid and Emergency Medical Services interviews.
9. Released stories on ISMA Sports and Medicine Committee training conference.
10. Worked cooperatively in other programs by providing information on availability of education materials, especially in the area of drug abuse.
11. Wrote special story for Madison County Medical Society meeting.
12. Wrote special story on Hendricks County Medical Society—student reception and dinner.
13. Wrote Tell City feature story on local clinic operation. Used in *Indianapolis* Star, Tell City papers, and *Louisville Courier-Journal.*
14. Provided material for new Kosciusko County Medical Society public relations program.
15. Worked with officers on closed circuit, 30-minute television program on Hoosier Teen Health Happening at AMA convention.
16. Provided information to students on physician assistant programs and other allied medical careers.
17. Worked with the AMA in developing radio and television spots on drug abuse.
18. Provided divisions of AMA with material and information on a number of ISMA programs, etc.
19. Circulated story on health consideration during early football practice by ISMA Committee on Sports and Medicine.
20. Provided physicians with new "Guidelines on Sex Education" developed by Office of Superintendent of Public Instruction.
21. Worked with numerous representatives of media—answering questions and providing background materials for story development; i.e., medicredit, emergency medical services, Governor's medical education program, cost of medical care, physician-population ratio, ect.
22. Wrote and circulated rebuttal story on Senate Finance Committee's Medicaid report.
23. Provided details of programming for Hoosier Teen Health Happening to other states and individuals as guidelines for their own plans.
24. Prepared a column on health matters and distributed it to all dailies and weeklies in Indiana.

COMMISSION ON PUBLIC INFORMATION
Thomas O. Middleton, M.D., *Chairman*
Seymour W. Shapiro, M.D., *Vice-Chairman*
William B. Challman, M.D.
Louis H. Blessinger, M.D.
Kenneth D. Schneider, M.D.
Richard S. Bloomer, M.D.
Robert W. Harger, M.D.
Charles R. Alvey, M.D.
Don W. Boyer, M.D.
Reeve Peare, M.D.
Fred Dahling, M.D.
Barbara Backer, M.D.
William G. Moore, M.D.
Victor Johnson, M.D.

Governmental Medical Services

HOUSE ACTION: Ordered filed.

The commission has had many meetings this past year and many matters have been discussed. We have reviewed many of the unusual and outstanding CHAMPUS claims (former serviceman's dependents Medicare). Seven or eight members of the commission have reviewed these claims either in conference or on telephone conferences. Throughout the year we have had about five telephone conferences from the state headquarters to review the outstanding CHAMPUS claims. We had an organizational meeting on November 15, 1969; other meetings were on January 25, April 22, June 10 and July 8, 1970.

Some of the plans for the commission for the year included the following:

1. To find an alternate plan for Medicaid.
2. A utilization review of the CHAMPUS program.
3. A program to have a continuing updating of the Blue Shield and California Relative Value Scale Schedule.
4. Recommend to the anesthesiology section of the Indiana State Medical Association that re-negotiation for a new contract for anesthesia with the government in the CHAMPUS program be made.

In April, 1970, the commission met with Blue Shield representatives, Mr. Kilborn and Mr. VanDyke. We were unable to find a way to answer the problem of upgrading Blue Shield indemnities schedules. Actually we learned that all new plans (Blue Shield) were sold on a usual and customary fee basis. It remains a mystery as to what is a "usual and customary fee basis."

The commission heard complaints from

the Indiana Association of Anesthesiologists and authorized the obtaining of a new contract for the group. In addition, the commission decided that the Indiana State Medical Association discuss and ask for increases in fees under the CHAMPUS program. An increase of two and one-half units was approved and agreed upon.

After many heated sessions and words, it was the desire of the commission that our Indiana State Medical Association must find a place of trust and loyalty within all those groups with which we deal. This should include the welfare department, Medicare and Medicaid and also Blue Shield.

As the year progressed, it was apparent that the fiscal agent for the government was falling back in its efforts to keep up with this fiscal portion. Many problems of tardy, unpaid, slow, underpaid claims became larger. Errors have been compounded and refractured as new problems of personnel and machines became apparent. We have been able to "bird dog" these problems with the able assistance of Blue Shield's Mr. Kilborn and Mr. VanDyke. Eye-to-eye and face-to-face conversation with representatives of Blue insurance and welfare have improved all our relations. We have attempted to greatly reduce the number of rejected claims in the Medicaid group of claims.

The Commission on Governmental Medical Services is very outspoken in its desire *not* to be a claims-investigating committee, but they were very willing to promulgate and adjudicate outstanding claims. Many errors in Medicare and Medicaid during the past 12 months were not the fault of physicians. It is our hope that this will become public information. The two-fold patient-physician relationship of the past has suddenly become three, four or even ten-fold, with Medicare and Medicaid programs, and the result has been of the same magnitude.

Physicians' complaints concerning claims have been reviewed and researched and we have tried to please all within the limits of the law.

The Indiana State Medical Association received and filed over 15,000 claims in the CHAMPUS program for a twelve-month period. Almost 15,000 claims were paid in the same period of time. The commission reviewed and approved an average of 15 claims per month.

As new members join our association we shall try to keep them informed as to the best way to process the paper work on CHAMPUS, Medicare and Medicaid. The financial outlays for these programs in Indiana are most staggering to a stable person and the most unbelievable task that a national health insurance could produce makes us realize that we have but put "three coins in a fountain." It was in the middle of this past summer that we heard from the Health, Education, and Welfare secretary that a price tag has been put upon one of the national health insurance plans. The price mentioned was close to forty billion dollars for one year.

JEROME E. HOLMAN, JR., M.D., *Chairman*
RAMON B. DUBOIS, M.D., *Vice-Chairman*
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FRANCIS H. GOOTEE, M.D.
FRANK BARD, M.D.
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TOM S. SHIELDS, M.D.
J. F. HINCHMAN, M.D.
LEE H. TRACHTENBERG, M.D.
MICHAEL J. MASTRANGELO, M.D.
D. D. SWIHART, M.D.
GLEN V. RYAN, M.D.

Public Health

HOUSE ACTION: Filed for information with the recommendation that the recommended approach of the Tuberculosis Section of the State Board of Health be circulation to the membership.

The Commission on Public Health conducted a lengthy discussion on the air pollution problem. Present as a resource person at two of the meetings was Mr. Perry E. Miller, Director of the Engineering Bureau, Indiana State Board of Health. The commission was advised that in comparison to programs and activities in other states in the Midwest, Indiana falls considerably short. It was further advised that if an increased effective program is to be achieved in Indiana, the State Legislature must grant additional funds to accomplish this. Mr. Miller submitted a budget outlining specific needs to upgrade air pollution control programs.

The commission asked the Board of Trustees of the Indiana State Medical Association to give consideration and to undertake an in-depth study of the problem of air pollution. We further asked the Board of Trustees to formulate a resolution on air pollution from automobile exhaust and direct this toward the automobile manufacturers and that representatives of the Commission on Legislation be directed by the Board of Trustees to appear in person in support of the Indiana State Board of Health environmental control budget before the next convening of the Indiana General Assembly. These matters were discussed by the Board of Trustees and referred back to the commission for implementation. In carrying out this directive from the Board of Trustees, letters were sent to two members of the Pollution Subcommittee of the Health and Welfare Study Committee on Legislation informing these legislators of our organizational and commission's interest in the problem of air pollution and volunteering to make our group available to the study group for consultation on this problem.

As an additional approach to the subject of air pollution the Commission on Public Health invited a representative of the Commission on Convention Arrangements to one of its meetings and proposed that the subject of medical aspects of air pollution be covered in the program of the 1971 convention. D. S. O. Waife said he would propose at the next meeting of the Commission on Convention Arrangements that a morning or afternoon session be devoted to the subject of medical aspects of air pollution. D. Waife was also informed that at a recent regional public health meeting, there had been an excellent presentation of the venereal disease problem and that such a presentation would be desirable to include in the 1971 meeting of the Indiana State Medical Association.

Considerable time was spent at two of the meetings of the commission discussing two proposed pieces of legislation. One, on the matter of requiring laboratories who do venereal disease testing to report the results to the State Board of Health which would, in turn, notify the local health department and they, in turn, would contact the doctor and alert him to the fact that he had a positive case and see if he wished assistance in the epidemiology of the case. The other proposed legislation would authorize local boards of health to employ attorneys and provide funds in their budgets for the payment of these attorneys. The chairman of the commission was directed to present these legislative proposals to the Board of Trustees requesting their referral to the Commission on Legislation. These proposals for legislation were approved by the Board of Trustees at its meeting on June 14.

As directed by the House of Delegates, the commission discussed the Indiana State Medical Association Resolution 69-11 and House Enrolled Act 1290 dealing with physical examinations and testing for tuberculosis of all school employees. After much discussion and thoughtful consideration of the issue, the commission recommends that the word "physical" be eliminated from line 10 of House Enrolled Act 1290 and the Board of Trustees were so notified.

The commission discussed the status of the curriculum on public health in the Indiana University School of Medicine. The chairman was requested to communicate with the Dean of the medical school and inquire as to the curriculum on public health. It was further recommended that the dean of the Indiana University School of Medicine be invited to one of the commission meetings.

The commission discussed the teaching of venereal disease in teachers' colleges. It was decided that the chairman would correspond with members of the committee which has the responsibility of making recommendations concerning instruction in teachers' colleges and that this committee would be informed that the subject had been discussed and that the commission is anxious to support any activities on their part which increases specific knowledge of candidates for teaching degrees in health as far as venereal disease, in its entire application, is concerned.

The Board of Trustees referred to the Commission on Public Health Resolution 69-37 introduced by the Owen-Monroe County Medical Society concerning teacher certification for health education. The Commission on Public Health recommends that the Board of Trustees shall endeavor with appropriate educators' associations to change the requirements for certification so that a teacher will receive proper preparation for instructing in health education.

The Director of the Tuberculosis Division of the Indiana State Board of Health, Dr. Russell S. Henry, requested approval by the Commission on Public Health of a new approach to the eradication of tuberculosis which the Indiana State Board of Health is in the process of implementing as follows:

It is recommended that the following approach to tuberculosis eradication in Indiana by the Tuberculosis Section of the Indiana State Board of Health.

First Priority:

That all active cases be under drug therapy, isolated if an open case and all close contacts be examined. A tuberculin test should be had at least ninety (90) days after the contact is broken and all reactors be treated prophylactically for one year;

Second priority:

That all previously known cases of reinfection type of tuberculosis be examined as to their present status. Those cases that have been known to have inactive disease and are found to be still inactive at the time of the re-examination and have reliably proved they have had adequate drug therapy to be discharged with no further follow-up;

That all patients who have never been treated with anti-tuberculosis drugs and those who have had less than one year drug treatment as well as new active cases be given at least one year of drug treatment, after which time they will be discharged with no further follow-up, provided the cases are declared inactive at the end of the one or two-year treatment;

The determination of what constitutes adequate drug treatment is to be determined by the examining physician. There are several types of cases to consider. What is considered to be adequate drug treatment in one type of case will not be considered adequate in another type of case. Examples:

1. A case of over five years inactivity, still inactive and never been treated, one year of I.N.H. is considered sufficient.
2. Any case who was treated with I.N.H. during the active stage and who converted to negative sputum in two to three months with corresponding chest x-ray improvement, one year of I.N.H. is considered sufficient.
3. Any case that failed to convert to negative sputum in three months, thereby requiring multiple drug therapy, must be treated with proper multiple drugs for a period of not less than two years.

The above covers the old inactive cases that had single drug treatment. New cases starting treatment within the past two years and some older cases have been on multiple drug therapy or at least should have been. In these cases, if the chest x-ray improved and the sputum converted to negative within two to three months, one year of treatment will suffice. Those who converted after three months should be on effective drug therapy for the full two years.

Third priority:

That all new school enterers in the first and kindergarten grades be tuberculin tested and all positive reactors treated for one year with I.N.H. Also, that all close associates of the positive reactors be examined to find the possible source case and that other children in the family (if any) also be tuberculin tested. Any other positive reactors in the home to be treated for one year with I.N.H.;

That children in grades over the first year who are positive reactors be treated for one year with I.N.H. with no follow-up of their associates;

That all close associates of positive reactors under five years of age be examined as possible source case as well as tuberculin testing all other children in the family (if any) and the positive reactors treated for one year with I.N.H.;

That all recent converters be treated with I.N.H. for one year with no follow-up of associates if the reactor is over six years of age.

This new approach is endorsed by the Commission on Public Health and it is recommended that the Board of Trustees approve this change.

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EARLE U. ROBINSON, M.D.
DON C. FIELDS, M.D.

Voluntary Health Agencies

HOUSE ACTION: Approved.

The Commission on Voluntary Health Agencies was constituted by the following members:

(1st Distr.) Albert Ritz, Evansville
(2nd Distr.) Robert H. Rang, Washington
(3rd Distr.) T. A. Neathamer, Scottsburg
(4th Distr.) Harry R. Baxter, Seymour
(5th Distr.) William G. Bannon, Terre Haute
(6th Distr.) Wayne Endicott, Greenfield
(7th Distr.) Norman R. Booher, Indianapolis
(8th Distr.) Lowell W. Painter, Winchester
(9th Distr.) A. Earl Applegate, Frankfort
(10th Distr.) Walfred A. Nelson, Gary
(11th Distr.) Lloyd L. Hill, Peru
(12th Distr.) Richard Willard, Bluffton
(13th Distr.) Frank J. McGue, Michigan City
(At Large) M. O. Scamahorn, Pittsboro
(At Large) Charles Rushmore, Indianapolis
(At Large) Max Hoffman, Covington

The organizational meeting of the commission was held on Sunday, January 25, 1970, and the commission was notified that President Steen had appointed the chairmen of the commissions for the coming year and had appointed Dr. Norman R. Booher as chairman and Dr. Wayne Endicott as vice-chairman. The commission went on record as giving a vote of confidence to

both Dr. Endicott and Dr. Booher and elected Dr. Charles Rushmore as secretary.

A large part of the first commission meeting was spent in orientation for the work for the year and considering the suggestions made by the president of the association and the Board of Trustees. Plans for the year were perfected as noted below in the activities of this commission.

One of the great problems presenting itself to the commission, as usual, was that of communication between the segments of the ISMA, the members of the state association and the lay public.

For this reason, the chairman was ordered to seek a meeting with the Commission on Public Information, which he did, as noted below.

The commission seriously considered the feasibility of the organization of a new Indiana Health Council and the chairman was ordered to create a special study committee for studying this problem.

As is customary, at its January meeting, at least one-half of this meeting was devoted to meeting with the executives and presidents of the voluntary health agencies of Indiana.

Represented at this meeting were: Indiana Heart Association; American Cancer Society, Indiana Division; Indiana Society for Crippled Children and Adults; Mental Health Association in Indiana; Indiana Tuberculosis Association; Indiana Society for Prevention of Blindness; Cystic Fibrosis; and United Cerebral Palsy.

As has become customary there was a very free discussion between the members of the commission and these groups and the commission was very pleased to have many expressions of obviously sincere satisfaction on the part of voluntary health agencies with the cooperation of the Indiana State Medical Association in programs involving them.

Together with these representatives of the voluntary health agencies a joint scientific meeting was planned for the fourth year, to be held as a part of the annual meeting of the Indiana Public Health Association on April 23, 1970. A joint committee between the commission and the agencies was appointed to work out the details of this program and obtain the speakers.

A special committee made up of two members of the commission and four representatives of the agencies was appointed to study the feasibility of the reformation of the Indiana Health Council.

In the interval between the first meeting in January and the second meeting on April 23, 1970, the members of the commission spent a great deal of time on their assignments as liaison representatives to two or more of the voluntary agencies, receiving their reports, studying them, and making recommendations on the reports to the commission.

The joint meeting with the Indiana Public Health Association and the Indiana Tuberculosis Association, held on April 23, produced a very good program which fit in the general scheme of the meeting, which was, "The Place of Allied Help in the Future Delivery of Health Care." The commission felt that this meeting was an excellent springboard not only in the scientific material presented, which was apropos, but most important from the point of view of public relations of the Indiana State Medical Association.

At the conclusion of the scientfic program on April 23, the commission held its second regular meeting of the year.

At this meeting the first decision was that a revision of the Indiana Health Council should be approached with caution and that the existing health council should be strengthened to provide more necessary coordination and that the Indiana Public Health Association be encouraged to play a greater coordinated role in the work of the present Indiana Health Council.

At this meeting the remainder of the questionnaires of the various voluntary health agencies having statewide programs were reviewed and the following organizations approved for the current year as having met the criteria of the Indiana State Medical Association: American Cancer Society, Indiana Division; The Arthritis Foundation; Indiana Society for Prevention of Blindness; Indiana Society for Crippled Children and Adults, Inc.; Central Indiana Chapter, National Cystic Fibrosis Research Foundation; Tri-State Epilepsy Association, Inc.; Indiana Heart Association; Indiana Association for Mental Health; Indiana Chapter, National Multiple Sclerosis Society; Indiana Tuberculosis Association; United Cerebral Palsy of Indiana, Inc.

One of the most momentous things to happen to the commission during the year was the reception of the legal opinion of the attorneys for the Indiana State Medical Association, which had been requested from the Board of Trustees, asking the legal position of the ISMA to change the word used within the program of the voluntary health agencies from "recognized" to "approved" and to consider at the same time the legal position in relation to dissemination of information available to this commission to persons other than members of the Indiana State Medical Association. This legal opinion was received by the commission under date of March 17, 1970. Permission was given to change the verb from "recognized" to "approved" and to disseminate the information to lay sources under certain definite restrictions. These restrictions include the fact that it be noted the approval is definitely by the Indiana State Medical Association, through its Commission on Voluntary Health Agencies; that the criteria be clearly stated; that we should not list any voluntary health agency which has failed to meet the criteria and that each agency listed on the published information shall have given permission to have its name so listed.

In line with the legal decision, the commission has obtained, in writing, the desire of each of the voluntary health agencies on the approved list to change the word from "recognized" to "approved" and permission to have their name included with the others on the approved list distributed to general sources of information.

At the April meeting of the Board of Trustees, the chairman of the commission presented this information to the Board, who approved the use of the word "approved" rather than "recognized" and the publication of the placards, as published in other years.

At the June 14 meeting of the Board of Trustees, the chairman presented the following list as being the list to whom the approved agency list would be disseminated:

Indiana State Chamber of Commerce; local Chambers of Commerce; Junior Chambers of Commerce; State Better Business Bureau; membership, Indiana State Medical Association; membership, all approved agencies (also all unapproved agencies); daily newspapers, weekly newspapers, radio, television (statewide); Indiana Public Health Association; Indiana Health Council; Woman's Auxiliary, Indiana State Medical Association; Indiana Dental Association; Indiana State Board of Health; Headquarters, Regional Medical Programs; Indiana Health Careers, Incorporated; Indiana Pharmaceutical Association; Indiana Nurses Association; Community Service Council-Indianapolis; mayors—all Indiana cities; all state representatives and senators; governor; county health officers; all recognized comprehensive health planning organizations; Indiana Manufacturers Association; labor unions; school systems; service organizations—Lions, Rotary, Kiwanis, Optimists, Exchange; fraternal organizations—Elks, Moose, Masonic; veterans' organizations; state women's clubs; Home Demonstration Clubs; universities; Farm Bureau.

The Board of Trustees approved this list and also the printing of the placards on 8½ x 11 stock and at this time the cost

was quoted to the Board as approximately eight dollars per thousand.

It also approved the distribution to the membership of the state medical Association, similar to that of the past—either by inclusion in the News Flash, or other information going out for distribution, or by the field secretaries.

The following letter was presented to the Board of Trustees as being the covering letter which should be sent out, together with the placards, which would list the names of the agencies. This letter was approved, in principle, with the understanding that minor changes might be made:

"The members of the commission are happy to report to the House of Delegates that we feel the development and continuation of the program of the commission this year reached an epic in development because for the first time we will now be able to give to the public at large accurate information on the voluntary health agencies that have met the criteria of this association.

"You should be aware of these voluntary health agencies at a time when their role in medicine should be stronger than ever."

The commission requests the approval of the House of Delegates of this program and its permission to follow this program in a similar vein next year.

The members of the commission have spent far more hours on the work of this commission than this report can reflect.

The commission is very grateful for the cooperation of the members of the Commission on Public Information of the ISMA who have assisted in procuring the legal opinion and who have assisted us in working towards wider dissemination of the information and for greater participation on the part of the membership of the Indiana State Medical Association; also for the thousands of volunteers who devote their time to the health interests of the general public.

The commission wants to again publicly acknowledge the very fine executive work of Mr. Kenneth Bush, who has carried a heavy load of the work of this commission; we are also grateful to Mr. James Waggener and to the officers of this association for their unusually fine cooperation this year, and we remain very grateful to Miss Eleanor Chapple, who has been our faithful secretary since the commission was organized.

NORMAN R. BOOHER, M.D.,
Chairman

Medical Economics and Insurance

HOUSE ACTION: Filed for information.

During the years 1969-1970, the Commission on Medical Economics and Insurance of Indiana State Medical Association continued its slow progress toward the goal of providing a package of benefits, at group rates, for all Indiana State Medical Association members.

The program of disability insurance is growing, in participation and in stability. It is now available even to members with previous medical problems. The commission recently introduced the group term life insurance plan to the membership; its rates are very attractive, and the acceptance by membership has been good.

The possibility of providing group "malpractice" protection has intrigued the commission for several years, and this year the membership was surveyed by letter. Happily, 53% of you replied telling us your experience and conclusions concerning liability insurance. We know now that many of you liked the idea of group coverage and are accepting the concept of peer review to ensure it. We also know that most of you are happy with your present coverage. The data are being examined in many ways, and we hope to offer a detailed analysis in this *Journal* in the near future.

The status of retirement plans and the benefits and pitfalls of incorporation are continually reviewed. They provided the background for the panel discussion on just such projects at the 1969 ISMA convention.

The commission thanks you for your cooperation and welcomes your suggestions and criticism.

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JACK W. HANNAH, M.D.
WILLARD BARNHART, M.D.
THOMAS G. HAMILTON, M.D.

Medical Education and Licensure

HOUSE ACTION: No action.

The Commission on Medical Education and Licensure met on January 11, 1970, April 9, 1970, June 14, 1970 and August 16, 1970. In addition to the regular commission members in attendance, Dr. Steven Beering attended each meeting as a guest and consultant regarding several problems. A SAMA representative also attended some of the meetings. Other guests and consultants invited to assist the commission in its deliberations included Dr. Robert Stonehill, Dr. Raymond Murray, Dr. Jerry Royer and Mr. Don Dian. Areas of concern and problems assigned to the commission for study and recommendation were:

1. Postgraduate medical education in Indiana.
2. The Indiana statewide medical education system.
3. Licensure of foreign medical graduates.
4. The preceptor program of ISMA and Indiana University School of Medicine.
5. Speakers Bureau.
6. MECO—Medical Education and Community Orientation.
7. Physicians' assistants.

1. POSTGRADUATE MEDICAL EDUCATION IN INDIANA. Study has been made to encourage increased attendance to postgraduate programs. In this effort five programs will be given in hospitals in communities over the next year. The use of resort areas with the families being invited is also under consideration. The number of hours available in Indiana in 1969, as compared to the surrounding states, is 759 hours with a range of from 257½ hours in Kentucky to 1,326 hours in Pennsylvania. The schedule of programs has been made available by general mailing and is to be published in *The Journal* of the Indiana State Medical Association.

Compulsory postgraduate medical education for ISMA membership is being studied by the commission. Material from Oregon has been requested and circulated to the commission for study before definite recommendations are made by the commission.

2. INDIANA STATEWIDE MEDICAL EDUCATIONAL SYSTEM. The Commission followed the progress of the Governor's Commission on Medical Education and studied its resolution. The commission supports the plan presented by this resolution and recommends the full support of the ISMA to get legislative approval and enabling legislation for this resolution as well as to support the Indiana University School of Medicine in its implementation.

3. LICENSURE OF FOREIGN MEDICAL GRADUATES. Because of the critical situation existing in Indiana and especially some areas regarding available physicians, foreign medical graduate licensing was studied. Two areas were considered: (a) The temporary licensure of foreign medical graduates for institutional practice under supervision, (b) Licensure by en-

dorsement of foreign medical graduates on the same criteria as U. S. graduates, eliminating the three-year residency requirement in the state of licensure. This was approved by the commission and forwarded to the ISMA Board of Trustees where it was defeated. The subject was again discussed and again the commission recommended that the Board of Trustees of ISMA recommend to the Indiana Board of Medical Registration and Examination that the three-year residency requirement after licensure in another state prior to Indiana licensure by endorsement be removed.

4. PRECEPTOR PROGRAM. The commission studied the possibility of recognition of preceptors both by presentation of certificates of appreciation and possibly by medical school faculty appointment. Faculty appointments will be delayed until the development of the new department of family practice at Indiana University School of Medicine. Workshops and training seminars for general practice preceptors are being considered with the help ot the students. A list of 51 students was given to the commission. This is 11 more than last year.

5. SPEAKERS BUREAU. The list of speakers in the ISMA Speakers Bureau was completed and will be maintained in the headquarters office of the ISMA. It is to be published in *The Journal* of the ISMA. The list is also to be sent to hospitals having medical education programs. Arrangements for expenses and/or stipends for the speaker are to be made by the speaker and the agency asking for his service.

6. MEDICAL EDUCATION AND COMMUNITY ORIENTATION PROGRAM OF SAMA (MECO). This program is one which is sponsored by SAMA and provides that medical students are given educational opportunities at pre-clinical levels or before the freshman year, as well as clinical, in community hospitals. The students work under the supervision of a specific doctor and are paid by the hospital. The commission recommended this program be approved in principle for Indiana and referred it back to the ISMA Executive Committee.

7. PHYSICIAN ASSISTANT PROGRAM. Much time was spent in studying the Physician Assistant Program—the needs, utilization, and allied problems. Several consultants testified regarding these programs. Much material was sent to the commission members for study. The commission is well informed regarding the problems and is continuing its study but is at this time not ready to make recommendations relative to programs in Indiana. Two major problems are present in Indiana: (a) What to do about the trained assistants coming into the state and (b) what to do about developing physicians' assistant training programs in Indiana.

In relation to the first problem, the commission recommended that Indiana not license physicians' assistants but rather recommend they be certified and registered and that the Medical Practice Act of Indiana be modified to permit physicians' assistants to provide their services under the supervision of physicians licensed to practice medicine in Indiana.

The commission has no recommendations regarding the second problem. In view of the many problems, the lack of uniformity of entrance requirement, curriculum and educational requirements, type of certification and degree, and the lack of guidelines regarding the patients' relationships, the hospital relationships and the M.D.s relationships to the new health-care workers; and in the absence of AMA guidelines in these areas, the commission has no recommendation. It will continue to gather information and statistics prior to a decision. A poll is to be made from the specialty groups in Indiana as well as the individual physicians in order to establish needs, job descriptions and other pertinent information.

I, as chairman, wish to thank the ISMA staff for their help with the many duties related to this commission. I also wish to thank each commission member who worked so hard on this very important commission. The help of the consultants and guests has also been invaluable and is greatly appreciated.

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MERRITT O. ALCORN, M.D.
GLENN W. IRWIN, JR., M.D.
(ex-officio)

SUPPLEMENTAL REPORT MEDICAL EDUCATION AND LICENSURE

HOUSE ACTION: Approved.

Dr. Ross Egger accepted the position as Chairman for the General Practice Preceptorship Program for the ISMA Commission on Medical Education and Licensure.

The final recommendations of the ISMA Commission regarding Physicians' Assistants is as follows: (See Summary attached to minutes.)

Summary of recommendations of the Commission on Medical Education and Licensure regarding Physicians' Assistants.

1. The Commission endorses the concept of the Physicians' Assistant.
2. The Commission recommends that Physicians' Assistants be registered in Indiana, rather than licensed, and that changes be made in the Medical Practice Act to permit Physicans' Assistants to provide services under supervision of a licensed physician.
3. The Commission is formulating a suggested policy for the training and utilization of Physicians' Assistants for the ISMA by:
   a) Surveying the clinical sections of ISMA.
   b) Surveying the general membership of ISMA.
   c) Continued study of nationwide experience.
   d) Utilizing the AMA statement of policy when available (probably after the next clinical meeting of the AMA in Boston).
   e) Establishing liaison with Nurses Training Schools.
4. In the meantime, the Commission feels that the Physicians' Assistant or the Physicians' Support Personnel concept is worthwhile and should be implemented. At our present state of knowledge, the most satisfactory approach suggested is thought to be:
   a) Increase the available pool of nurses.
   b) Extend the training and abilities of nurses to permit them to qualify as Physicians' Assistant (e.g., perform duties heretofore done only by physicians).
   c) Encourage and support such programs as that of the Regenstrief Foundation and utilize their experience and the experience of others in formulating a final policy of the ISMA.

Special Activities

HOUSE ACTION: Approved as amended. Entire report referred to Board of Trustees.

During the 1969-70 year, the Special Activities Commission concerned itself with the problems of alcoholism, drug addiction, incompetent physicians and a recurring problem with orientation of new members to the Indiana State Medical Association. Numerous other small problems were brought to our commission's attention and were suitably solved with the situations corrected.

The commission studied the trials of alcoholism and adopted the recommendations which were developed by Dr. Hanus J. Grosz of Indianapolis. They were as follows:

1. That the Indiana State Medical Association declare its intent to actively support and implement the 1956 and 1966 resolutions on alcoholism passed by the AMA House of Delegates.

2. That the ISMA Board of Trustees be authorized to consider establishing a Commission on Alcoholism and Drug Addiction and complete.

3. That the Indiana State Medical Association encourage local hospitals to set up facilities for admission treatment and referral of alcoholics (as recommended by the AMA, American Hospital Association, and American Psychiatric Association) and postgraduate refresher courses on alcoholism and drug addiction.

4. That the Indiana State Medical Association recommend to the state legislature to appropriate more funds for working in the field of alcoholism and funds for work in the field of drug addiction.

5. That the Indiana State Medical Association recommend that the Indiana state mental hospitals set up adequate alcoholism and drug addiction treatment unit.

Judiciary Committee

HOUSE ACTION: The ISMA officially recognizes the need for a Medical Disciplinary Act and shall actively seek through its appropriate commisson or committees the enactment and implementation of such an act.

During the first two years of the previously adopted orientation program, both interest and attendance were poor despite the fact that all new members were requested to attend (both a state orientation and a district orientation program) onee during the first two years of practice, with all expenses paid. Apathy reigned supreme and only approximately 15% attended. Obviously the program was dying on the vine. The need for an orientation program to encourage ISMA members to know about and be interested in their state organization still existed. It was also apparent that a new approach was necessary.

An audio-visual presentation was discussed. It was felt if such a program could be developed, it could be shown to medical students, district societies, county societies or any other feasible medical gathering. Mr. John Walters. ISMA field secretary, was requested to develop a sample program, which he did very expertly. By using transparencies with an overhead projector and a prepared seript, he gave a good and attention-getting presentation. Two members of the commission met with Dr. Glenn Irwin, who felt such a presentation could and should be made available to the students. It could also even be shown on the school's statewide closed circuit television system whieh is now operational.

Another suggestion was the use of a loose-leaf binder with a tape recorder, both of which would be given each new member. They then could be used at his home for not only orientation to ISMA but also for other information which would help him start his medical praetice.

The Special Activities Commission recommends that the Board of Trustees appropriate Mr. Walters funds for a pilot program which he will present in the fall to the Board and to the commission members.

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EVERETT DONNELLY, M.D.
PETER E. GUTIERREZ, M.D.
ROBERT P. ACHER, M.D.
HANUS J. GROSZ, M.D.

Aging

HOUSE ACTION: Filed for information.

The Commission on Aging met on three occasions in 1970, January 11th, March 12th and July 12th. The first meeting was basically an organizational meeting and the outlining of the problems to be discussed during the year.

The general plan was to follow-up the projects of the past year, and encourage the implementation of the resolutions that were passed by the House of Delegates.

There was much discussion during the year on the methods of implementation of the medical care in the nursing homes and continued treatment homes. Many of the members of the commission, and presumably members of the ISMA, have many questions regarding the Certification for Continued Treatment under Medicare. It was arranged to have Mr. Kilborn and Mr. VanDyke meet with the commission to try to answer these questions. A long discussion ensued on the problems of how a person is certified and under what standards the patient is certified.

The major answer from the Blue Cross was that SCA has tightened up the money and because of this, patients are not being certified. We were not able to get a specific list of criteria that are necessarily fulfilled before a person can be certified. Either this is not known or it is not being revealed.

Another project that was discussed at some length was the problem of training someone to take care of the chronically ill person who is home-bound. This problem is always acute. Blue Cross was asked if there are possibilities of funding of home care through Medicare or Medicaid. We were told it would be looked into.

Again we discussed at some length the 75th percentile and have the same answers that have been around for a long time; nothing new was gained by this.

The commission has presented two resolutions to the 1970 House of Delegates. One of these, regarding more specific policy changes in Social Security, we feel would be of benefit to the aged, and by using the policy of partial disability in addition to total disability, we believe this policy would be of major benefit to the aged, as well as people who are approaching retirement.

The second one is aimed at broadening the facilities at hand to give a more balanced, and hopefully more economical, way of taking care of aged patients by the addition of home-bound care. We believe that it is more economical to treat people in their own home than in hospitals, continued treatment or nursing home facilities.

The Commission on Aging discussed at great length the methods by whieh the Indiana State Medical Association can deal more specifically, with more strength, in the areas of aging. It is our opinion that in the coming years we should broaden our base, and align ourselves with all the groups of both private citizens, as well as governmental agencies, that are interested in problems of the aging.

Since our knowledge is mainly medical and our specific interest is basically limited to the medical treatment of the aged. we should attempt to add this knowledge to those that are interested in housing, socialization and finance, etc. This approach may give a much better understanding and therefore much better opportunity to plan

necessary changes in programs for the aged.

W. R. VAN DEN BOSCH, M.D., *Chairman*
JOEL W. SALON, M.D.
BERNARD B. ROSENBLATT, M.D.
R. E. BUCKINGHAM, M.D.
RAYMOND DUNCAN, M.D.
A. W. CAVINS, M.D.
JAMES R. GUTHRIE, M.D.
JOHN O. BUTLER, M.D.
THEODORE R. HAYES, M.D.
DANIEL RAMKER, M.D.
GEORGE W. WAGONER, M.D.
THOMAS A. ELLIOTT, M.D.
DANIEL BERNOSKE, M.D.

Commission on Emergency Medical Services

HOUSE ACTION: Ordered filed.

We met four times during the year. My report was originally lost in the electronic process of being recorded. I didn't think you would want to read through any more data than you already have. We did three things for you. We conveyed to the government of our state to all the agencies that it seeks to represent that in our state in the important area of emergency medical services, ISMA speaks for the physician and if they have plans, if they have projects, they come to us first. The second thing we were able to do is to bring to the legislature for enactment at this session a code which will regulate ambulance service throughout the entire state. This is printed up in the form of a resolution and also in the form of a law which will be distributed to all of the component county medical and district medical societies. The third thing which we have done is participate with the AMA in the national Jaycees campaign, and you will be contacted at a local level by many representatives of the Jaycees who would like to work with county medical societies to do something within the county to serve the community along with the physician. They have accepted our leadership on this and would be willing to work with us very closely and to provide good relations and good public relations. I hope that you will treat them kindly. It has been my privilege to be your chairman for two years and to organize this commission. I want to thank you for this opportunity. As I relinquish it now I will tell you it has been a lot of fun. There have been a few fights. I have enjoyed every minute of it. My appreciation to you.

No reports received from INTERPROFESSIONAL RELATIONS, MEDICAL-LEGAL REVIEW COMMITTEE, SPORTS AND MEDICINE.

Report of Board of Trustees

Report: A
(A-70)

Subject: Resolution 69-12—INSURED AMBULATORY DIAGNOSTIC BENEFITS

HOUSE ACTION: Approved with the recommendation that third parties be encouraged to make available to their insured these outpatient services without later hospital facility duplication.

Resolution 69-12 was referred to the Board of Trustees last year by the House of Delegates. The Board's Liaison Committee with Blue Cross discussed this resolution at length with the Medical Advisory Committee of Blue Cross earlier this year.

It was generally agreed that such outpatient diagnostic studies would have to be performed in facilities which were approved by the hospital medical staff which was accepting these reports as a part of their medical records. Secondly, it was agreed that the outpatient facility performing the examination must be licensed by the Indiana State Board of Health. Reports from unlicensed facilities could not be accepted.

The mode of payment for these services presents serious problems. Blue Cross has adopted the concept of "pre-admission" testing as long as these services are performed in hospital departments. Blue Cross is not allowed to pay for physicians' service on outpatients. The Board favors continuation of this policy. Currently, Blue Shield does not cover benefits for outpatient *pre-admission* laboratory or x-ray studies.

It seems that some sort of plan could be worked out between Blue Shield and Blue Cross to pay for pre-admission testing done outside of hospital facilities. This should result in a significant lowering of the overall cost of hospitalization for the patient. The problem was then taken up at a joint meeting of the Executive Committees of Blue Shield and Blue Cross on June 17, 1970. The subject was in turn referred to the staff of Blue Cross-Blue Shield, and a report from them is to be received by no later than October 1, 1970.

Therefore, the Board of Trustees of the ISMA strongly recommends that hospital staffs and Blue Shield and Blue Cross be urged to recognize testing done outside of outpatient facilities for pre-admission and that the Board of Trustees is hereby requested to work toward accomplishing that goal.

Report: B
(A-70)

Subject: Resolution 69-14—MEDICAL EDUCATION

HOUSE ACTION: Accepted.

The Indiana State Medical Association does support and has in the past supported strongly the Indiana Plan for Medical Education in the state of Indiana. We have unstintingly cooperated with the Indiana University School of Medicine's administrative officers to support and help them in their present and future needs for planning for medicine in the state of Indiana. Many of our men in the cooperating areas, along with the directors of medical education, both full and part-time, have worked cooperatively with the faculty advisory groups from the Indiana University Medical School in sponsoring medical education on a local level. The Board Liaison Committee has relatively continuing informal contact with the Indiana University faculty committee.

Future activities have been discussed and since they are only in the planning stage, no definitive action can be taken in these areas; however, in the area of curriculum in the university, changes have been made with the aim in mind of providing to the state of Indiana more interns and residents and to help in several localities in the state of Indiana to secure additional physicians in the future by encouraging our graduates to remain in Indiana. The local areas will now be the site of education on an elective basis in the senior year for the entire student body in Indiana University. The elective areas will be in the several specialties as well as general practice. A change in curriculum, also, brings about in university structure a Department of General Practice or Family Medicine.

The program has begun and we are building toward what we hope will be a broad usage. As in all plans, there may be several years of time involved before fruition in the form of actual increase in the numbers of doctors practicing in Indiana occurs, especially in the area of family medicine. However, the Board of Trustees of the Indiana State Medical Association feels very strongly that the Indiana plan is the plan that is to be preferred above any and all other plans for medical education in Indiana.

The Board of Trustees urges that all members of the House of Delegates as well as members of this association, continue to support the Indiana Plan for Medical Education and work toward its further implementation.

Report: C
(A-70)

Subject: Resolution 69-16—HEALTH MANPOWER

HOUSE ACTION: Accepted.

This is not a definitive report on Resolution 69-16, referred by the House to the Board of Trustees. It is more of a status report of the various activities which have taken place and are taking place in the specific areas mentioned in the resolution.

The question of providing adequate health manpower is an overwhelming one, as everyone knows. It is felt that the Indiana State Medical Association Commission on Medical Education and Licensure should undertake a more active and definitive role in planning of training programs, etc., that might be involved in the acquisition of health manpower personnel in Indiana. The Board of Trustees should be involved in directional planning but should act only upon whatever activities the Commission on Medical Education and Licensure should propose; however, neither the Board of Trustees nor the Indiana State Medical Association should become directly involved in the educational processes involved in the training of ancillary medical personnel. This type of ancillary help will be featured in the care of various segments of the population as proposed in national health care systems under discussion.

The present status of physicians' assistants is as follows: There is a pilot program being undertaken at the Regenstrief Institute, under the direction of Dr. Raymond Murray, utilizing as a core group registered nurses who are actually capable of extending their ability above and beyond the clinical experience that is theirs now. There have been some conversations with the dean of the university toward the establishment of a less complicated physicians' assistant program in the matter of training. Throughout the next year further discussion will take place and the method or plan of operation might be concluded and a trial training program instituted. In the discussion it was felt that the legal and professional status of physicians' assistants and/or any allied health personnel should be not one of licensure, but rather one of certification, since all of their activities should be and must be under the responsibility and direct supervision of practicing physicians.

The allied health personnel training programs are very adequate in some cases and in others need some realignment, perhaps strengthening, in various areas. It may very well be over a period of time that some of these particular specialty training groups, such as radiological technicians and laboratory technicians, will be divided in several sections or responsibility areas so that rather than all conforming to the current assistant's programs, training might be limited in some areas to provide technicians who are able to do only specific tasks. This could shorten training time for delivering certain health services and still provide exceptionally trained technicians via fuller programs.

These and many other things are problems in training and supplying of allied health personnel, including physicians' assistants. It is a program which is under the supervision of the Indiana State Medical Association, through the Board of Trustees, the commissions and committees, and one which will continue to be studied and scrutinized in the future.

The Board of Trustees recommends that the House go on record supporting the fact that ISMA should, through its Commission on Medical Education and Licensure, set forth the requirements for an appropriate curriculum, recommend the time period of training, recommend the pre-admission requirements for people admitted to the paramedical classes program and strongly urge every state university in Indiana to become involved, along with the local hospital in that area, in training allied health personnel.

Furthermore, we recommend that the Commission on Medical Education and Licensure vigorously work with interested state universities to implement the program and to support legislation accomplishing these goals.

Report: D
(D-70)

Subject: Resolution 69-27—REVIEW OF BLUE CROSS-BLUE SHIELD CERTIFICATES

HOUSE ACTION: Accepted.

There is misunderstanding and confusion regarding Blue Cross and Blue Shield insurance certificates. Such misunderstanding and confusion is brought about because of many different contracts which are primarily negiotated between the unions and management getting together and deciding what they want and what they will pay for. They then ask the insurance carrier how much they will charge for such contracts. Basically in the past there have been Standard, Preferred, Usual and Customary policies. (However, no more Standard Policies will be sold.)

Many of these policies are inadequate to protect Blue Shield certificate holders, even the policies which are primarily determined by what labor and management want and amount of money available to provide such.

No physician is present, or participates officially in discussion of coverage presented to major corporations for medical coverage. We believe possibly a physician present could be of aid. However, union and management usually have already made up their minds of what they want. Also many contracts are negiotated out of state, such as New York, Detroit; the plan then is forced to go along or not participate at all. More than 60% of Blue Shield business is this kind.

There is marked discrimination of compensation among medical, surgical care and hospital benefits. We do not know how this is determined. To our knowledge, a computer does this.

We recommend that the Board of Trustees of the Indiana State Medical Association review the certificates of Blue Cross and Blue Shield and offer recommendations to improve the coverage of Blue Cross and Blue Shield certificates. A review might be made, but consideration must be given to what the individual wants, what the physician wants and what the carrier can provide for the amount of money involved.

We further recommend that the Board of Trustees of the Indiana State Medical Association report its findings to the House of Delegates of the Indiana State Medical Association at its next annual meeting in 1971.

Report: E
(A-70)

Subject: Resolution 69-13—PHYSICIAN SHORTAGE
Resolution 69-15—DELIVERY OF HEALTH CARE

HOUSE ACTION: Accepted. Report referred to Commission on Medical Education and Licensure for further study of definition of "physician assistant" and other responsibilities.

In considering Resolution 69-13 and 69-15, the Board which received a status report of the Joint Ad Hoc Committee on Medical Education, recognizes that the statewide medical education program will help considerably in increasing medical student enrollment. However, it is not certain that such programming is the answer from the long-term point of view.

Such a program, however, might be instrumental in developing, over the years, a nucleus of instructors who could meet faculty assignments for a future second medical school, which would be a more satisfactory method of training additional physicians.

Additionally, the Indiana State Medical Association should strive to *assist in every way possible in obtaining funds through appropriate legislation and other activities*

for affiliated hospitals in the state associated with the medical education plan. Many practicing physicians are involved in teaching in the hospitals and are, consequently, compelled to partially neglect their practices. These physicians should be compensated for their effort in the same manner as instructors at the Indiana University School of Medicine.

The committee further reported in its year-long study that there are a few more physicians each year entering family practice. Every resident and internship opening at the Methodist Hospial, Indianapolis, was filled this past year for the first time.

The committee has also endorsed the development of a Chair for Family Practice at the Indiana University School of Medicine.

The well-organized nursing profession in Indiana should be additionally developed as allied medical personnel assigned to assume some of the physician's responsibilities under his supervision. Nurses providing such service could actually be utilized in small communities to function in this capacity with direct liaison with a local practitioner or clinic.

Technicians and corpsmen returning from service could also be trained to fulfill similar responsibilities. Medical-legal aspects of such an approach should be considered in depth as well as the type of registration or licensure for such personnel.

Group practice by physicians in rural communities was cited as an inducement to physicians to practice in smaller communities. The Tell City Clinic plan was specifically pinpointed, as an example.

Report: F
(A-70)

Subject: Resolution 69-18—CONTINUING MEDICAL EDUCATION

HOUSE ACTION: Accepted.

The Board of Trustees, concerning the matter of methods of providing continued certified education including self-assessment programs, recognizes that there is value in developing residency programs in hospitals to which practicing physicians could return on a periodic basis for specialized training in any area.

This could be for a period of two or four weeks on a four month or six months' basis. This, of course, would be particularly applicable for a group of physicians who practice together.

Efforts should be made to establish such residencies on a full time, dynamic basis which would fulfill the recommendation that Indiana physicians possess the most modern medical knowledge to deliver the highest quality medical care.

Report: G
(A-70)

Subject: Resolution 69-19—PEER REVIEW

HOUSE ACTION: Approved as amended.

Medical review is an educational process for the reviewers and those who are reviewed and assists medical societies through this endeavor in collecting important data useful to the profession in providing better health care to the public which they serve and to refute the false claims of our critics. Medical Review is a term describing the activities of physicians in observing, monitoring and reviewing the professional activities of physicians exclusively by their colleagues, including total patient care, fee review and identifying practice patterns.

In joint county societies it is suggested that a single medical review committee be structured. Small societies with limited membership may find it feasible to form a single medical review committee in conjunction with one or more other small societies.

The Indiana State Medical Association will also develop a Medical Review Committee to aid and assist the County Medical Review Committees when called upon and the President will be directed to appoint this Committee with the approval of the Board of Trustees.

Finally, the Medical Review Committee will be a standing committee of the ISMA.

Report: H
(A-70)

Subject: Resolution 69-20—COLLEGE HEALTH FORMS

HOUSE ACTION: Accepted with the recommendation that further study be continued.

A committee of the Board of Trustees of the Indiana State Medical Association has met with the college health physicians in an attempt to obtain a unified health examination form—a form which will be easily completed and quickly interpreted.

There are several reasons why a new form cannot be instituted immediately:

1. Each university has particular mechanical equipment to process their forms—this equipment is too expensive to be changed immediately.
2. The health physicians in the various universities tend to stress different portions of the examination (as physicians in private practice tend to do also).
3. Purdue University is not requiring, at the present time, a health examination. They strongly urge and feel that it is quite valid and good, but, they have had difficulty in enforcing the examination.

Members of the medical staff of the various universities have been very cooperative, particularly Dr. John Miller, Indiana University, who is chairman of the Committee on College Health Physicians. In the very near future Dr. John Miller plans to spend a period of time studying how the computer may be utilizied in assisting university physicians in the health study of their students; through this a good, comprehensive, universal, pre-admission health form may be obtained.

Report I
(A-70)

Subject: CONVENTION SITES AND FACILITY REQUIREMENTS

HOUSE ACTION: Accepted.

In the past, convention sites have been named by the House of Delegates five years in advance. Recently, much interest has been shown by various component medical societies to host the annual meetings in various parts of the state.

In an effort to cooperate with the local medical societies, the Board of Trustees would like to present to the association what it believes are the minimum facilities that are necessary to host the annual convention of the Indiana State Medical Association. In this manner the component medical societies can determine well in advance whether their city meets the minimum requirements or not. The following represents the minimum facilities required to host the convention:

Total Registration—1500 to 2000

1. Facilities located in the same building
   (a). Exhibit area—20,000 to 25,000 square feet
   (b). Minimum of 15 meeting rooms
   Seating from 30 to 80 for meals
   Auditorium space to accommodate minimum of 500
   This room should have a stage; public address facility; projection facility; ample ventilation and cooling facility
   Space for storage of exhibit crates
   Press room and room for headquarters office and work room for headquarters staff
   Adequate parking
2. Facilities not necessarily in same building as exhibits
   (a). 500 to 600 class A hotel rooms
   (b). Banquet space to feed 600—or if luncheon instead of banquet, room to serve 1,000

(c). Theatre for entertainment—seating 600 minimum

(d). Gaslight type program requiring a facility having a large room, plus three or four smaller rooms to accommodate from 600 to 1,000 people for drinks, food and entertainment

(e). Facilities for meeting of Executive Committee and luncheon (15 people)

(f). Facilities for breakfast and meetings of Board of Trustees (50 people)

(g). Golf course

(h). The city should be easily accessible by air and other transportation

(i). Good warehouse and eartage facilities

The cost of the convention facilities, that is, the items listed "in the same building" should, insofar as possible, be defrayed by the income obtained from the sale of exhibits and tickets for the various dining or entertainment functions.

Societies interested in hosting the annual convention of the association should extend an invitation to hold the convention in their city to the Board of Trustees by June 1st of each year for the meeting to be held five years hence. The Board shall study all proposals and make their recommendation or recommendations to the House of Delegates for the final decision on the selection of a site.

Societies hosting the convention will be expected to establish committees designated by the state association and whose functions will be to carry out only these matters specifically referred to the local committee by the Commission on Convention Arrangements.

Report J
(J-70)

Subject: Resolution 69-24—REPORTING ON FINANCIAL STATUS

HOUSE ACTION: Accepted.

The 1969 House of Delegates adopted Resolution 69-24 which said: "THEREFORE, BE IT RESOLVED, that the Board of Trustees report each year to the House of Delegates a recommendation as being an appropriate escalation in the dues structure based upon the Consumers Price Index, as promulgated by the U.S. Bureau of Statistics of the U.S. Department of Labor."

The Board of Trustees early in the year appointed a special committee of the Board to review the financial status of the association. The latter was composed of Dr. Gilbert Wilhelmus of Evansville, chairman; Dr. Lester Hoyt of Indianapolis, treasurer; Dr. Lowell Hillis of Logansport and Dr. Otis Bowen of Bremen, to study and prepare a budget for the forthcoming year.

The Board has adopted a proposed budget and finds we face a deficit in the operation of our association and the Journal in the coming fiscal year of $38,804.27 or $9.88 per member. Copies of this report have previously been sent to all delegates and alternate delegates to the State Medical Association. The Board, therefore, recommends this House of Delegates approve an increase of $10.00 in the dues of Indiana State Medical Association to become effective January 1, 1971.

A copy of the proposed budget and the cost per member follows:

The Cost of Operations is Broken Down as Follows:

	Cost	*Cost Per Member*
For the operation of the Board of Trustees; Executive Committee; AMA Delegation; Officers' expense; Commissions and Committees	$66,300.00	$16.87
Teen Health Program	25,000.00	6.36
Society Officers Conference	1,500.00	.38
Headquarters office operation	224,373.00	57.09

Headquarters operation figures are:

	Cost	*Cost Per Member*
Employee hospitalization insurance	2,400.00	.61
Building insurance, Bond and theft insurance	6,400.00	1.63
S.S. tax	4,050.00	1.03
State unemployment tax	125.00	.03
Federal unemployment tax	215.00	.05
Loss on convention	10,000.00	2.54
Real estate taxes	9,000.00	2.29
Total cost from General Fund for operations	317,173.00	80.70
Deduct Total Income	282,636.00	71.91
Estimated deficit in General Fund	$ 34,537.00	8.79

The Journal Account

Estimated total income	64,674.68	
Estimated total expense	68,941.95	
Estimated Deficit	4,267.27	1.09
Total Estimated Deficit General Fund and Journal	$38,804.27	$9.88

Resolution No. 70-1

Subject: DISCONTINUANCE OF MANDATORY ORIENTATION PROGRAM

HOUSE ACTION: Approved as amended.

WHEREAS, the Board of Trustees has been charged with implementing our orientation program for new members, and

WHEREAS, the Board has worked diligently to accomplish the mandate of the House of Delegates, and

WHEREAS, the attendance at these meetings has been less than 5% of our new members and since no punitive action has been provided to force compliance with the Resolution passed by the House of Delegates in 1967;

THEREFORE, BE IT RESOLVED, that this House rescind its previous action thereby abolishing the orientation program but strongly urge that all county societies establish an orientation program suited to their individual needs, and the Board of Trustees of Indiana State Medical Association, through its Committee of Orientation shall continue to explore practical methods of orientation of new members of the Association, and that the Board report its progress in this matter to the House at its next annual session, and;

BE IT FURTHER RESOLVED, that Section 1 of Chapter 1 of the Bylaws be deleted, and that present Sec. 2., Sec. 3., Sec. 4.; and Sec. 5., be renumbered Sec. 1., Sec. 2., Sec. 3., Sec. 4.

Resolution No. 70-2

Subject: REDUCTION OF NUMBER OF RESIDENCY PROGRAMS

HOUSE ACTION: Rejected.

WHEREAS, there is a shortage of family practitioners in the United States, and,

WHEREAS, there are roughly four times as many approved residency positions as there are U. S. medical school graduates each year, and,

WHEREAS, the solution to the health care needs of our citizens is not to turn out more specialists and fewer family practitioners, and,

WHEREAS, with the cooperation of the American Academy of General Practice, residency programs are being developed in family practice,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical

Association instruct its delegates to the next American Medical Association Convention to introduce a resolution directing the AMA Council on Medical Education to formulate a program to decrease the number of approved residencies by roughly three-fourths, and,

BE IT FURTHER RESOLVED, that this same resolution will direct the Council on Medical Education to report back to the 1971 AMA House of Delegates as to what progress has been made in implementing the residency position reduction.

Resolution No. 70-3

Subject: STUDY DEVELOPMENT OF A RELATIVE VALUE SCHEDULE

HOUSE ACTION. Approved.

WHEREAS, a large percentage of payments for medical services are now being provided by third party mechanisms, prepaid medical insurance and governmental programs, and,

WHEREAS, there is considerable discussion between physicians and these payment mechanisms regarding establishment of fees, and,

WHEREAS, many physicians are now using California Relative Value Studies in basing their fee structures.

NOW, THEREFORE, BE IT RESOLVED, that the Board of Trustees of the Indiana State Medical Association instruct the appropriate commission or commissions to make a study of the applicability of the California Relative Value program or similar type relative value plan in the state of Indiana and report the results of the study, with recommendations, at the next annual meeting of the Indiana State Medical Association in October, 1971, for action by the House of Delegates.

Resolution No. 70-4

Subject: FEE NEGOTIATING MECHANISM

HOUSE ACTION. Approved.

WHEREAS, government and prepaid insurance mechanisms provide for usual, customary and reasonable payment for medical services in many programs, and,

WHEREAS, through edict of bureaucratic officialdom, payment has been restricted to the 75th percentile in Medicaid cases, and,

WHEREAS, no negotiating mechanism is presently available in the state of Indiana,

NOW, THEREFORE, BE IT RESOLVED, that the Board of Trustees of the Indiana State Medical Association appoint an appropriate commission or body to study this problem and submit to the next annual meeting recommendations for the formation of a suitable group to negotiate equitable payments in the future.

Resolution No. 70-5

Subject: OPPOSITION TO PLAN OF GOVERNOR'S COMMISSION ON MEDICAL EDUCATION

Resolution withdrawn.

Resolution No. 70-6

Subject: UTILIZATION REVIEW

HOUSE ACTION: Rejected.

WHEREAS, physicians are trained and are obligated to care for the ill in the best way they know how, and,

WHEREAS, the shortage of physicians is causing more and more of their time to be taken in the care of the sick, and,

WHEREAS, the duties of the physicians in the hospitals are requiring increasingly more time, and,

WHEREAS, most of these hours in the hospital are spent on endless committee meetings that the government is requiring, and,

WHEREAS, the Utilization Review Committee physicians are now being asked to police other doctor's patient charts as to the patient's need to be hospitalized or continued in the hospital, and,

WHEREAS, only the physician entering a patient into the hospital really knows the reasons for the admission, and,

WHEREAS, another physician cannot possibly ascertain from a chart whether a patient needs to be or not be in a hospital, and,

WHEREAS, the Medicaid and Medicare insurance intermediary is requiring such a program, and,

WHEREAS, the implementation of such a program will only bring about more bad publicity on the medical profession, and,

WHEREAS, the physicians of Indiana did not ask for such a program,

NOW, THEREFORE, BE IT RESOLVED, that the physicians of Indiana go on record as opposing the use of their peers to peruse the admissions of other physicians and that the Medicaid and Medicare intermediary do such police action themselves.

Resolution No. 70-7

Subject: REPEAL OF UNITED NATIONS CHARTER

HOUSE ACTION: Rejected.

WHEREAS, the United Nations Charter was ratified by the United States Senate and President, July 28, 1945, after obtaining authority from a sufficient number of state legislatures, and,

WHEREAS, we have witnessed a steady disintegration of the principles upon which this nation was founded as a direct result of being a member of the United Nations, and,

WHEREAS, the Congress of the United States has ignored for eight years a bill to repeal the United Nations Charter,

NOW, THEREFORE, BE IT RESOLVED, the Indiana State Medical Association requests the legislature of the state of Indiana to repeal the United Nations Charter for this state so that other states will follow their example until three-fourths of our states have done likewise.

Resolution No. 70-8

Subject: INSURANCE COVERAGE FOR HOME HEALTH CARE

HOUSE ACTION: Referred back to Commission on Aging for further study and clarification as to detail of implementation.

WHEREAS, there seems to be an ever-increasing awareness of the need of high-quality medical care for the aged, and,

WHEREAS, there is no simple answer since the medical needs of the aged are multiple, complex and variable from time to time, and,

WHEREAS, the Commission on Aging and the Indiana State Medical Association are fully and completely aware of the increasing, and almost overwhelming cost of these projects of care for the aging,

NOW, THEREFORE, BE IT RESOLVED, that those third parties, such as Blue Cross, independent insurance companies and government agencies, but not exclusively these, seriously look into the feasibility of the use of prepaid or insurance coverage to provide payment for paramedical personnel, to be specially trained to look after the elderly people, who may be able to be maintained in their own homes. It is our sincere opinion that this would be done at a lesser cost than keeping a person in a nursing home, and much less cost than keeping a person in a continued-care home, and tremendously less costly than hospitalization, and that by this provision, the family doctors might thereby be encouraged to treat as many of these people in their offices and homes as feasible.

Resolution No. 70-9

Subject: DEVELOPMENT OF PARTIAL DISABILITY CATEGORY

HOUSE ACTION: Rejected.

WHEREAS, the Indiana State Medical Association is unalterably adherent to the

policy that the doctors of Indiana, as members of the Indiana State Medical Association, give the very highest quality of medical treatment available, and,

WHEREAS, there seems to be considerable inequity in the regulations of the Social Security Disability provisions, namely that a person is either well and able to work fully, or totally and possibly, permanently disabled, prior to being able to be considered for compensation, and,

WHEREAS, there are many people who are able to do some work or who have, because of the nature of their work, reached an age where that type of work is no longer possible, but their inability to carry out their usual occupation is not due to specific physical or emotional disability, but is merely the result of age, and,

WHEREAS, we are convinced that a person's self-esteem is dependent on his ability to be independent and self sustaining,

NOW, THEREFORE, BE IT RESOLVED, that the principle of "partial inability" to carry out their usual occupation, whether it be due to age, disability of a physical, or emotional nature; be considered as an alternative to be adjudged to being totally disabled and unable to do work. This policy would also provide for a period where the person could work, within limits of his ability, and would have opportunities for rehabilitation that are not encouraged by the total disability concept. It is our opinion that this would be economical in that it would encourage rehabilitation.

Resolution No. 70-10

Subject: MEDICAL LIABILITY LIMITS

HOUSE ACTION: Approved as amended.

RESOLVED that the Committee on Future Planning recommends to the Indiana State Medical Association House of Delegates that legislation be prepared for presentation to the Indiana State Assembly by interested members of that Assembly to combat on a legal basis the ever-increasing problems of medical liability.

One specific recommendation is that legislation be prepared for use of medico-legal panels for pre-trial investigation, or compulsory arbitration. Another should be designed to correct the abuses associated with the contingency fee concept, as well as an in-depth study and definition of statutes of limitations.

Resolution No. 70-11

Subject: METHOD OF ELECTION OF CERTAIN OFFICERS

HOUSE ACTION: Rejected.

RESOLVED, that the Committee on Future Planning recommends to the Indiana State Medical Association House of Delegates that the Constitution be amended to include the following ways of getting new, wider and more active participation of the membership:

(a) ISMA trustees and AMA delegates and members of the ISMA House of Delegates be elected by a vote of the entire membership which they represent,

(b) All elections should be by mail ballot,

(c) At least two candidates, for every trustee and delegate office, be submitted by the nominating committee,

(d) To win a candidate must have a 30% plurality of the entire membership —not just a majority of the votes cast. If the candidate receives less than the required 30%, the election would be invalid and a new election would be held.

Resolution No. 70-12

Subject: SUPPORT OF INDIANA PLAN MEDICAL EDUCATION

HOUSE ACTION: Adopted.

WHEREAS, the Indiana University School of Medicine for the past two bienniums has developed and operated its new statewide program of medical education made possible by Senate Enrolled Act No. 359, and,

WHEREAS, the original objective of increasing the number of graduate and continuing medical education programs is being met, and,

WHEREAS, the further objective of increasing the retention of Indiana University graduate physicians, as well as drawing physicians from out of state by the aforementioned objective, and,

WHEREAS, continued funding of this program is necessary for continued and increasing fulfillment of its objectives,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association commend the Indiana University School of Medicine on its far-sighted program, which has been successful, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Associaion House of Delegates recommend to the State Legislature at its next session to continue to fund Senate Enrolled Act No. 359.

Resolution No. 70-13

Subject: PHYSICAL EXAMINATIONS FOR SCHOOL EMPLOYEES

HOUSE ACTION: Adopted and recommended the Commission on Public Health in liaison with State Board of Health study and distribute a special report concerning requirements for public school employee physicial examinations and develop a standard form for the entire state which conforms with the law.

WHEREAS, the present Indiana law concerning teachers' examinations and tuberculosis testing of school personnel is vague and subject to varying interpretations at the local county and school district levels, and,

WHEREAS, definite language in the law as to the type of tests, extent of examination, etc., is desirable and needed for purposes of uniformity of cost accounting, delivery of service, etc.,

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates, in duly constituted assembly, endeavor to modify the existing law of the statute books of the state of Indiana so as to definitely ascertain the type of tuberculosis test, extent of examinations of school personnel, frequency of examinations, etc., and,

BE IT FURTHER RESOLVED, that this be achieved through the proper commissions and/or committees of the Indiana State Medical Association so that the context of this resolution can be conveyed to the next state legislative session of the Indiana State Legislature.

Resolution No. 70-14

Subject: SUPPORT OF GOVERNOR'S COMMISSION ON MEDICAL EDUCATION PLAN

HOUSE ACTION: Adopted.

WHEREAS, the Governor's Commission on Medical Education has made specific recommendations in its report which will enable the Indiana University School of Medicine, through the mechanism of a statewide network of universities and community hospitals, to provide undergraduate medical education, enabling the immediate increase in the number of medical students trained by the Indiana University School of Medicine, and,

WHEREAS, the recommendations would, by 1973, enable the Indiana University School of Medicine to increase its class enrollment by 100 students, and,

WHEREAS, these recommendations would enable the Indiana University School

of Medicine to immediately increase the production of physicians in the state of Indiana which, together with prior legislation improving the distribution of physicians in Indiana, would help to relieve Indiana's physician shortage,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association commend the Governor's Commission on an excellent report, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association commend the Indiana University School of Medicine and its consultants, working with the Governor's Commission on Medical Education in helping to prepare an excellent workable program as outlined in the report, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association recommend to the State Legislature at its next session, that the Governor's Commission report and its recommendation be accepted and that legislation be enacted to enable funding and implementation of these recommendations.

Resolution No. 70-15

Subject: SEMI-ANNUAL MEETINGS—HOUSE OF DELEGATES

HOUSE ACTION: Referred to Board of Trustees for study of the cost of a second session, executive session only.

WHEREAS, the activity of the Indiana State Medical Association has become so momentous that a single session of the House of Delegates is not sufficient to conduct and perform all of the duties of the association,

NOW, THEREFORE, BE IT RESOLVED, that a yearly spring business session be established and mandated to aid in the conduct of the business and affairs of the association.

Resolution No. 70-16

Subject: MEDICAL DEPARTMENT—BOARD OF CORRECTIONS

HOUSE ACTION: Adopted.

WHEREAS, many members of the LaPorte County Medical Society have either worked in the Michigan City Prison medical department or have served as consultants and are aware of the medical needs of the inmates of the Michigan City Prison, and,

WHEREAS, the LaPorte County Medical Society has annually for the past eight years recommended to the state government through the state medical association the idea of organizing the medical care in the Departmcnt of Corrections in a more efffi-cient manner, and,

WHEREAS, a survey of the medical needs of our state prisons by the U. S. Public Health Department in 1968 confirmed this recommendation, and,

WHEREAS, on July 19, 1970, Governor Edgar Whitcomb publicly stated that he has established a commission whose purpose is to improve conditions and programs in our state correctional institutions, and,

WHEREAS, the Indiana State Board of Corrections is responsible for the total medical care of all inmates under their supervision,

NOW, THEREFORE, BE IT RESOLVED, that the LaPorte County Medical Society urges the Indiana State Medical Association to again recommend to the state government the establishment of a medical department within the Board of Corrections.

Resolution No. 70-17

Subject: REPORTING DISPOSITION OF PREVIOUS HOUSE ACTIONS

HOUSE ACTION: Adopted.

WHEREAS, much attention, ingenuity, inspiration and concern are invested in the reports, resolutions and speeches presented to each annual meeting of this House of Delegates, and,

WHEREAS, these matters are then carefully and thoughtfully discussed before Reference Committees, and recommendations are then formulated by the committee, and,

WHEREAS, the House of Delegates further considers each proposition before adopting a decision, and,

WHEREAS, certain recommendations are then given to the Board of Trustees or to a commission, or to a specific officer for further action,

NOW, THEREFORE, BE IT RESOLVED, that at the next succeeding meeting of the House of Delegates, each matter so delegated be reported back to the House with respect to its disposition or status, and,

BE IT FURTHER RESOLVED, that the Executive Secretary be given the responsibility of presenting this information to the House.

Resolution No. 70-18

Subject: REPORTING OF AMA DELEGATION POSITIONS ON ISSUES

HOUSE ACTION: Adopted.

WHEREAS, the policies and the functioning of the AMA have significant impact and continuing effects upon practicing physicians, and,

WHEREAS, the decisions made by the AMA House of Delegates on matters such as the dues structure, ethical standards (e.g., abortion), educational requirements (e.g., phasing out internships), and relationships with third parties (such as governmental), are of vital concern to AMA members, and,

WHEREAS, the delegates to the AMA are entrusted with the responsibility of properly and effectively representing all the members of ISMA,

NOW, THEREFORE, BE IT RESOLVED, that the delegation to the AMA from ISMA be required to report to the Board of Trustees and to the House of Delegates how each delegate voted on every matter of substantial significance or involving controversy, and also any formal positions taken as a delegation, or as individual delegates, in election contests at each AMA meeting, and,

BE IT FURTHER RESOLVED, that such reports be made to the House of Delegates no later than its first meeting, at the annual convention.

Resolution No. 70-19

Subject: HOOSIER TEEN HAPPENING

HOUSE ACTION: Approved as amended.

WHEREAS, members of the LaPorte County Medical Society were both impressed and proud of the action of the Indiana State Medical Association in organizing the program "Teen Health Happening," and

WHEREAS, response to this program on the part of the teenagers was definitely favorable the LaPorte County Medical Society wishes to commend the present officers for their action in organizing the program. That we strongly recommend to the incoming officers that the program be a continuing event at appropriate intervals to assure its proper utilization, provided it is approved by the Board of Trustees.

Resolution No. 70-20

Subject: LICENSING OF MEDICAL ASSISTANTS

HOUSE ACTION: Adopted.

WHEREAS, legislation leading to the licensing of medical assistants has been suggested by various organizations, and,

WHEREAS, a number of hazards exist of equal importance compared to the advantages of such legislation,

NOW, THEREFORE, BE IT RE-

SOLVED, that a thorough study of this matter be conducted by an appropriate commission of the Indiana State Medical Association before any sponsorship or support of such legislation be conducted by the association.

Resolution No. 70-21

Subject: INEQUITIES IN DUES PAYMENTS

HOUSE ACTION: Adopted as amended.

WHEREAS, the Marion County Medical Society, and, perhaps, other county medical societies in Indiana, require applicants for membership, who are not elected to membership until after July 1 of any one year, to pay only one-half the amount of the annual dues, and

WHEREAS, the Marion County Medical Society, and, perhaps, other county medical societies in Indiana, do not require interns and residents to pay dues, and

WHEREAS, the American Medical Association has the same policies and

WHEREAS, the Indiana State Medical Association grants a reduction in dues only to those physicians elected to their first membership after October 1 of any one year, and

THEREFORE, BE IT RESOLVED, that Chapter XXX-County Societies, Sec. 12, of the Constitution and Bylaws of the Indiana State Medical Association be amended to provide that physicians who are elected to their first membership after July 1 of any one year be required to pay only one-half the amount of the annual dues.

Resolution No. 70-22

Subject: ABORTION POLL

HOUSE ACTION: Rejected and the intent of the resolution be referred to the Board of Trustees for its consideration. Urges a straw poll on question of abortion and AMA policy.

WHEREAS, the American Medical Association in its 119th Annual Convention, through the action of the House of Delegates, adopted a positive, permissive policy on abortion, in effect asking that such an operation be legalized, and,

WHEREAS, there was much controversy concerning such a resolution before its passage, and has been much more since that time, and,

WHEREAS, it is not at all certain whether such action represents the will of the majority of the members of the AMA,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association petition the American Medical Association to reconsider the action of the House of Delegates of the 119th Convention concerning abortion, and,

BE IT RESOLVED, that the Indiana State Medical Association poll its membership to determine the percentage favoring and not favoring the aforementioned resolution, such results to be forwarded to the AMA for their study and consideration.

Resolution No. 70-23

Subject: FINANCING OF RENAL DIALYSIS PROGRAMS

HOUSE ACTION: Approved as amended.

WHEREAS, advances in medical technology in the past decade make it possible for patients with "terminal" renal failure to live and be restored to a relativaly normal and productive life; and,

WHEREAS, the great majority of citizens of Indiana suffering from chronic renal disease are unable to obtain such therapy because existing sources and methods of financial support are grossly insufficient,

NOW, THEREFORE, BE IT RESOLVED that the Indiana State Medical Association recommend to and assist the Indiana General Assembly in exploring the methods of financially assisting this worthwhile program.

Resolution No. 70-24

Subject: MEDICAL FOUNDATIONS

HOUSE ACTION: Adopted as amended.

WHEREAS, the ability to practice under a fee for service concept is the cornerstone for the delivery of physicians' services, and

WHEREAS, delivery of the physicians' services at a reasonable cost to their patients has always been an important consideration of the medical profession, and

WHEREAS, we are constantly guarding to preserve the physician-patient relationship and its innumerable benefits, and

WHEREAS, the freedom of choice of both the physician and the patient must be preserved, and

WHEREAS, all facets of medical care must be maintained, and

WHEREAS, Medical Foundations have been established in several localities throughout the country to preserve the above principles, and

WHEREAS, these plans would therefore be administered and controlled by local medical societes for their own patients,

NOW, BE IT THEREFORE RESOLVED, that the House of Delegates of the Indiana State Medical Association refer the subject of Medical Foundations to the Board of Trustees or other appropriate committee for their study, and

BE IT FURTHER RESOLVED, that the Board of Trustees report back to the next regular meeting of the House of Delegates with a statement of their findings.

Resolution No. 70-25

Subject: ANNUAL MEETING PROGRAMS

HOUSE ACTION: Adopted as amended.

WHEREAS, changing patterns of medical practice have developed changing patterns in scientific medical education, and

WHEREAS, many feel the general scientific medical program no longer serves the need of today's physician, and

WHEREAS, our Association has been forced to expand its activities to include the fields of socio-economics, medical-legal, public relations and other non-medical fields,

THEREFORE, BE IT RESOLVED, that this House of Delegates declare the following to be the policy to be followed by the officers and the Commission on Convention Arrangements of the Indiana State Medical Association for its programming of our annual meetings:

(1) That the Convention Arrangements Commission shall delegate to the specialty medical organizations the responsibility for planning and conducting the scientific programs held during our annual meeting;

(2) That the officers and the Convention Arrangements Commission be responsible for planning and conducting programs dealing with socio-economic, medical-legal, public relations and other non-scientific matters;

(3) That the specialty programs may be arranged jointly by two or more specialty groups, if so desired, and further such meetings can be held concurrently.

Resolution No. 70-26

Subject: ORIENTATION PROGRAM

HOUSE ACTION: Rejected. See Resolution No. 70-1.

WHEREAS, the debate and representative processes of the ISMA in arriving at its constructive and realistic policies and progressive programs to deal with the

pressing and perplexing problems of medicine and rendering medical care today are often prolonged, sometimes impeded and rarely blocked but often misinterpreted and maligned by some of its membership and the public through misunderstandings, strong feelings and failure to understand the mechanisms of functioning of the ISMA, and,

WHEREAS, the need for a unified and understanding approach to the problems of medicine, organized and individual, was never greater and is becoming a vital necessity to the maintenance of good medical care for our patients and the public; and,

WHEREAS, a uniform and effective orientation program for new members and present membership would eliminate some of the impediments to a constructive, progressive and realistic approach to the problems of medicine by the ISMA arising from misunderstanding of the membership of the mechanisms of its functioning,

NOW, THEREFORE, BE IT RESOLVED, that the Board of Trustees of the ISMA be charged by the House of Delegates with the responsibility of formulating in any manner they see fit an effective, comprehensive and realistic orientation mechanism for new members and present members of the ISMA, and that the progress and results of the development of this orientation mechanism be reported to the House of Delegates annually; and,

BE IT FURTHER RESOLVED, that the above paragraph be incorporated in the Bylaws to replace Chapter 1, Section 1 of the Bylaws.

Resoluton No. 70-27

Subject: STANDARDS OF NON-MEDICAL DRUGS

HOUSE ACTION: Adopted as amended.

WHEREAS, the medical profession should provide leadership in matters with a medical or biological focus, and,

WHEREAS, there is presently a great need for authoritative standards regarding the non-medical use of drugs and euphoriant agents, especially with regard to their risks, addictiveness and mode of action, and,

WHEREAS, there is need for valid objective data rather than just opinions, and,

WHEREAS, our state has rich resources upon which we could draw for such information,

NOW THEREFORE BE IT RESOLVED, that the Commission on Public Health be urged to develop program under the auspices of ISMA to obtain the information and to formulate well-founded recommendations regarding such drugs and euphoriant agents, for the guidance of our members, and,

BE IT FURTHER RESOLVED, that the Commission on Public Information be charged with transmitting these results to the membership and to provide the public with such recommendations as may be deemed appropriate and timely.

Resolution No. 70-28

Subject: ENDORSEMENT OF INDIANA PLAN

HOUSE ACTION: Adopted.

WHEREAS, the education of more physicians and the training of greater numbers of allied health professionals is of widespread concern and under consideration by many interested groups, and,

WHEREAS, Indiana University School of Medicine has been notably in the forefront in developing innovative methods of expanding its capabilities and the maximum use of its resources, and,

WHEREAS, the Governor's Commission on Medical Education has been diligently making inventories and appraisals of the present and potential facilities and personnel in Indiana, and has been cooperating with the administration of the School of Medicine and with many other Universities of the state in planning for the further expansion of medical education,

NOW THEREFORE BE IT RESOLVED, that ISMA reiterate its endorsement of the "Indiana Plan" and commend the School of Medicine for its continued efforts in this endeavor, and,

BE IT FURTHER RESOLVED, that the Commission on Medical Education and Licensure be directed to seek maximum involvement in such planning, to maintain continuous liaison with the School of Medicine and with the Governor's Commission on Medical Education, and to provide counsel from ISMA,

BE IT FURTHER RESOLVED, that the Commission on Medical Education and Licensure keep the Board of Trustees and this House informed of the status of such planning and make recommendations and evaluations so as to enable ISMA to have an appropriate policy in these matters.

Resolution No. 70-29

Subject: HAZARDS OF GLASS DOORS

HOUSE ACTION: Adopted as amended.

WHEREAS, physicians are deeply involved in all aspects of public safety, and

WHEREAS, when physicians find situations that are extremely hazardous to their patients, especially children, we feel an obligation to work for the elimination of such hazards, and

WHEREAS, physicians are seeing more and more children seriously injured and severely lacerated by glass storm doors, and

WHEREAS, these injuries are caused by the child falling through the door or running his arms through the glass, and

WHEREAS, we do not anticipate the ways of children are going to change a great deal in the coming years,

NOW, THEREFORE, BE IT RESOLVED, that the design of such storm doors be changed to minimize the above mentioned potential and real hazards;

BE IT FURTHER RESOLVED, that the Indiana State Medical Association request the appropriate standing committee of the Indiana General Assembly to develop legislation to implement the intent of this resolution.

Resolution No. 70-30

Subject: UNIFORM AMBULANCE CODE

HOUSE ACTION: Adopted as amended.

WHEREAS, private and governmental efforts have sometimes been ineffective in their attempts to improve emergency medical services, and

WHEREAS, city, county and state governments have failed to participate effectively in the effort to improve emergency medical services, and

WHEREAS, preparation of state legislation would bring the public and government sectors into a coordinated effort with the health professions,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association cooperate with the appropriate standing commitee of the Indiana General Assembly in developing legislation that would upgrade ambulances and ambulance services in relation to emergency medical care,

BE IT FURTHER RESOLVED, that this resolution be brought to the American Medical Association to bring about similar action in all the states.

Resolution No. 70-31

Subject: INDIANA PLAN

HOUSE ACTION: Adopted.

WHEREAS, the Delaware-Blackford County Medical Society feels that its resolution of April 21, 1970 (and since withdrawn) regarding the Governor's Comission on Medical Education's recommendations for the establishment of seven satellite centers of medical education in the State of Indiana has been misunderstood; and,

WHEREAS, since that time members of the Delaware-Blackford County Medical Society have had the opportunity to study the report and recommendations of the Governor's Commission on Medical Education; and,

WHEREAS, members of the Delaware-Blackford County Medical Society have had the opportunity to observe the operation of a satellite program at Ball State University under the direction of Charles Boyer, Ph.D.;

THEREFORE, BE IT RESOLVED, that the Delaware-Blackford County Medical Society be on record as favoring the concept that quality medical education under the direction and accreditation of Indiana University School of Medicine can be delivered in satellite centers for medical education in the State of Indiana.

Resolution No. 70-32

Subject: FOREIGN MEDICAL GRADUATES

HOUSE ACTION: Approved. Referred to Board of Trustees for further study and appropriate action.

WHEREAS, the progressive physician shortage, especially in rural and small urban communities is a well documented threat to our citizens, and

WHEREAS, Indiana must compete vigorously with all other parts of our county for well qualified physicians, and

WHEREAS, foreign medical graduates are one source of such physicians (please see attached information)

THEREFORE, BE IT RESOLVED, that United States citizens who have satisfactorily completed 4 years in a foreign medical school and 2 years of satisfactory training as intern or resident in the U.S. be allowed to take the Indiana State Board examination for medical licensure without the requirement of the E.C.F.M.G. examination.

BE IT FURTHER RESOLVED, that a foreign medical graduate may be granted a temporary unlimited permit to practice medicine provided that:

1. He has an unlimited foreign license to practice medicine; and has passed the E.C.F.M.G. examination;
2. His permanent visa application is in process and the candidate signs a statement that he will make a declaration of intent to become a citizen as soon as legally possible;
3. Both the Indiana State Board of Medical Registration and Examination and the County Medical Society where the candidate desires to practice have documented thoroughly and approved all aspects of his desirability;
4. He is successful in the Indiana State Board examination.

FURTHER, the State Board, after carefully assessing the candidate's previous training, may waive (in certain exceptional instances) the 2 years U.S. training requirement for final licensure.

The Indiana State Medical Association strongly recommends the implementation of these resolutionss.

I. Source of candidates examined for licensure in U.S.A. in 1969 (J.A.M.A. 6/15/70)

Medical Schools	*No. Schools*	*No. Examined*	*No. Passed*	*No. Failed*	*Percent Failed*
Approved U.S.A.	84	4,627	4,360	267	4.1
Approved Canada	12	96	81	15	15.6
Foriegn Medical Schools	342	4,975	3,228	1,747	35.1

II. Approved Internships

U.S.A.—74% filled (31% by foreign medical graduates)
26% not filed

Indiana—13 hospitals, 22 approved programs, 220 positions
133 filled—60% (8% foreign medical graduates)
87 not filled—40%

III. Approved Residencies

U.S.A.—82% filled (32% by foreign medical graduates)
18% not filled

Indiana—20 hospitals, 50 approved programs
69% filled (9% foreign medical graduates)
31% not filled

IV. Example A - U.S. citizen or native born son

4 yr. medical school in Mexico
1 yr. Internship in Mexico
6 mo. Social Service in Mexico
Then can receive unlimited Mexican license
Then can take ECFMG exam
Then 2 yr. training in approved U.S.A. hospital
Then may take Indiana State Board exam
(7½ yrs. after college graduation)

V. Example B - Foreign Citizen

Unlimited license in foreign country
E.C.F.M.G. exam
2 yr. of training in U.S.A.
Declaration of Intent to become U.S. citizen
(currently 6 to 24 mo. delay)
Then may take Indiana State Board Examination

Conclusions: (1) Without foreign medical graduates, the current physician shortage would be even more severe.

(2). Indiana may well need to judiciously modify the barriers against F.M.G.s or introduce some flexibility into the system if it is to protect its present and future citizens from an increasing dearth of physicians.

Resolution No. 70-33

Subject: DUES INCREASE

HOUSE ACTION: Rejected.

WHEREAS, the I.S.M.A. Board of Trustees has requested a $10.00 increase of dues and,

WHEREAS, the proposed budget reflects specific areas of expenditure where this can be reduced significantly and,

WHEREAS, the I.S.M.A. need not operate with a deficit

THEREFORE, BE IT RESOLVED, that sufficient dues increase be allotted to cover cost of the Journal and only essential services. (2) Expenses for operation of Board of Trustees; AMA delegation and Officers and Commissions and Committees be reduced to cover only travel, lodging and minimal subsistence. (3) Various bodies shall meet only in the Headquarters office or convention sites. (4) Convention expenses are to be pared and/or fees raised to meet extra costs. (5) Programs such as Teen Health Happening shall be presented only when adequate funding is available, either from outside sources or by approved assessment on members.

Resolution No. 70-34

Subject: HEALTH CERTIFICATES FOR RELICENSING OF CERTAIN INDIVIDUALS

HOUSE ACTION: Adopted.

WHEREAS, it has come to the attention of the members of the Ninth District Medical Society that the Bureau of Motor Vehicles of the State of Indiana has a health form for renewal of drivers' licenses required for certain citizens, and

WHEREAS, if a personal physician refuses to certify the citizen's physical ability to operate a motor vehicle, relicensing is denied that individual, and

WHEREAS, such decisions which are a legitimate responsibility of that State Agency are being foisted upon the practicing physicians of Indiana with no legislative protection for possible liability, and

WHEREAS, physicians recognize the need and desirability of physical and mental certification for driver license but believe this is the responsibility of the Bureau of Motor Vehicles,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association House of Delegates go on record as opposing the requirement from personal physicians and urge all members of Indiana State Medical Association to not sign a certification, or rejection, of these citizens, and

BE IT FURTHER RESOLVED, that the Commission on Legislation of the Indiana State Medical Association be urged to formulate a legislative proposal to the state legislature in session January 1971 to remove this odious segment of the relicensing law as written.

Resolution No. 70-35

Subject: BLOOD AS A SERVICE

HOUSE ACTION: Adopted.

WHEREAS, the Supreme Court of our neighboring state of Illlnois has recently rendered a decision that held a hospital blood bank liable for damages in a suit in which a patient allegedly contracted hepatitis following a blood transfusion, and

WHEREAS, this ruling sets a precedent to define blood as a commercial product and not as a service, and

WHEREAS, there is presently no means of predetermining if blood or tissue contains a virus, and

WHEREAS, if this decision is carried out, it could result in numerous law suits that would cause many blood banks to close, interfere with medical decisions, and create a considerable increase in costs of blood and tissue transplants, and

WHEREAS, blood and tissue are portions of the human body, not a commercial product, and

WHEREAS, the use of blood in transfusions and in the use of tissue in transplants is a service, is not a sale,

NOW, THEREFORE BE IT RESOLVED, that the House of Delegates instruct the officers and appropriate commission of the Indiana State Medical Association to prepare legislation to be introduced at the next session of the General Assembly that would grant immunity, except for negligence in the use of blood and other tissue, as 25 other states have already done.

Resolution No. 70-36

Subject: BLOOD TRANSFUSIONS

HOUSE ACTION: Adopted.

WHEREAS, a lack of uniformity now exists in the courts and insurance carriers regarding unsatisfactory results from blood transfusions, and

WHEREAS, in some states this has been resolved by legislation defining such transfusions as a "service", not a "product",

NOW, THEREFORE BE IT RESOLVED, that the I.S.M.A. at the 1971 session of the Indiana General Assembly, attempt to obtain legislation declaring that blood transfusions are a medical service rather than a product for sale.

Resolution No. 70-37

Subject: INTRODUCTION OF LEGISLATION IN SUPPORT OF RENAL DIALYSIS PROGRAMS

HOUSE ACTION: Resolution No. 70-37, INTRODUCTION OF LEGISLATION IN SUPPORT OF RENAL DIALYSIS PROGRAMS, was considered along with Resolution No. 70-23. Resolution No. 70-23 as amended was adopted in lieu of Resolution No. 70-37 (see page 1519).

WHEREAS, it is estimated that 200 patients, of approximately 1,500 in Indiana who died of terminal renal disease in 1969, could have been saved had adequate programs and funding existed for treatment of the disease, and yet only 30 were saved, and

WHEREAS, there are only nine physicians in Indiana working with the artificial kidney and there also is a shortage of trained dialysis nurses and technicians, and

WHEREAS, the problems in the treatment of chronic renal failure are those of continued operating financial support and manpower training and development, and

WHEREAS, basically, the support of the renal dialysis and transplant programs is by patient and third party payments and the risk of catastrophic expense which can destroy the financial health of the patient and his family is greatest among the middle economic classes, and

WHEREAS, an adequate, reasonable public support of dialysis and transplant programs is vital because of their unstable financial situations and,

WHEREAS, experience indicates that an investment of $500,000 will generate $2,500,000 in patient and third party payments, now

THEREFORE, BE IT RESOLVED that the Indiana State Medical Association strongly support legislation which would establish a Renal Disease Advisory Committee and which would appropriate $500,000 per biennium to extend financial assistance to patients suffering from chronic, terminal renal diseases who need extraordinary care, including dialysis and transplantation.

Resolution No. 70-38

Subject: ENVIRONMENTAL CONTROL

HOUSE ACTION: Adopted substitute resolution for No. 70-38 and 39.

WHEREAS, the effects of environmental pollutants of life and health are being documented with increasing frequency and clarity, and

WHEREAS, specific instances in Indiana have pointed up its immediate importance to the people in our State; and

WHEREAS, the members of the Indiana State Medical Association are concerned with and responsible for health care for our citizens;

BE IT RESOLVED, that the Indiana State Medical Association, through its Commission on Public Health and Legislative Commission, pursue the matter through appropriately proposed legislation so that environmental hazards to health may be anticipated, prevented and/or corrected.

Resolution No. 70-39

Subject: SUPPORT OF ENVIRONMENTAL CONTROL LEGISLATION AND LIVESTOCK CONFINEMENT FACILITIES

HOUSE ACTION: Adopted substitute resolution 70-38 in lieu of 70-39. See 70-38.

WHEREAS, President Nixon, in signing the National Environmental Act, stated "the 1970's absolutely must be years when America pays its debts to the past by reclaiming the purity of its air, its waters, and our living environment," and

WHEREAS, the Indiana Chapter, American Academy of Pediatrics believes the implementation of preventive programs in the existing environmental control Boards of the State, or any agency which may be created in the future, would be the best tax dollar savings approach to the problem, and

WHEREAS, the USDA equivalent population of domestic animal waste in the State of Indiana is 25 million, greater than the human population of 5 million, and

WHEREAS, livestock confinement facilities are a new national pollution problem commensurate to domestic sewage problem sources, and

WHEREAS, domestic animals are the natural reservoir of several diseases transmitted to humans known as Zoonoses and a source of great danger because of our close proximity to such animals,

THEREFORE, BE IT RESOLVED that the Indiana Chapter, American Academy of Pediatrics urges the Indiana State Medical Association to give strong support to any acceptable legislation which will:

1) Ensure the best protection for, and beneficial use of the resources of the State of Indiana through preventive programs and continuing surveillance policies for comprehensive environmental development and control.

2) Develop and administer programs designed to prevent, control, and eradicate Zoonoses and other diseases secondary to environmental hazards.

3) Give the power to establish and adopt rules, guidelines, and regulations for domestic livestock confinement facilities which shall be defined as "a facility where cattle, calves, sheep, swine, horses, mules, goats, and fowl are corralled, penned, tethered, or otherwise caused to remain in pens or corrals where feeding is other than grazing."

Resolution No. 70-40

Subject: AMA CODING AND NOMENCLATURE SYSTEM

HOUSE ACTION: Rejected. Resolution to be referred back to the Indiana Society of Internal Medicine with an explanation of the action of the Reference Committee, informing the Society that if it feels the change is necessary, reintroduce the Resolution in 1971 and the Society be prepared to support its postion.

WHEREAS the need for a uniform system of coding and nomenclature in order to describe accurately the great variety of medical services has never been greater, and

WHEREAS the American Medical Association has prepared an accurate and current system of coding and nomenclature, and

WHEREAS State medical associations, specialty societies, and others have delayed their own efforts so as to be certain there would be one universal system of description of professional services, therefore

BE IT RESOLVED that this House support the system of coding and nomenclature of the American Medical Association, and

BE IT FURTHER RESOLVED that the ISMA House of Delegates urge Indiana Blue Shield to adopt the AMA system of coding and nomenclature as the universal system for description of medical services.

Resolution of Appreciation

Resolution to Athletic and Convocation Center, Notre Dame University, St. Joseph County Medical Society, Woman's Auxiliary to the St. Joseph County Medical Society, Randall's Inn, Ramada Inn and the South Bend Convention Bureau.

Adopted by acclamation.

WHEREAS, in order for a convention to function smoothly, the facilities must be adequate, comfortable, convenient and equipped, and

WHEREAS, the Athletic and Convocation Center, on the University of Notre Dame campus fulfills these requirements excellently, and

WHEREAS, the Center, unquestionably, is one of the finest meeting and convention locations thus far developed in Indiana,

NOW THEREFORE BE IT RESOLVED, that this House of Delegates express to the managment of the Center their thanks for cooperation and the use of this extraordinary facility and grounds as contributing factors to the success of this 121st Convention,

AND BE IT FURTHER RESOLVED, that thanks and appreciation be extended to the St. Joseph County Medical Society and its Woman's Auxiliary, to the management of Randall's Inn, the Ramada Inn, and to the South Bend Convention Bureau for the excellence of their cooperation and support.

Presidential Resolution

Adopted by acclamation.

WHEREAS, this past year has been one of increasing involvement by organized medicine in a multitude of areas including delivery of medical care and socio-medical-governmental economic problems, and

WHEREAS, the expansion of this involvement and the ever-increasing necessity for organized medicine to be constantly alert and acting to keep abreast of daily fluid situations involving medical practice is each day becoming more urgent, and

WHEREAS, the energies of the president of the Indiana State Medical Association, in order that he fulfill the demands of his office to oversee and direct the Association in these areas, must be at times boundless, and

WHEREAS, Dr. Lowell H. Steen, as president of the Association, has demonstrated and exercised these qualities of concern, energetic willingness to oversee the activities of the Association, and devoted endless hours in meetings and decision making for the Association and the private practitioner,

NOW, THEREFORE BE IT RESOLVED, that this House of Delegates express to him its gratitude and deep appreciation for his contribution and steadfast loyalty to this organization and to his fellow Hoosier medical practitioners.

Place of Future Annual Conventions

Dates and places previously set.

1971 - Indianapolis

1972 - French Lick

1973 - Indianapolis

1974 - Evansville

1975 - The Board of Trustees will recommend at the 1971 House of Delegates the convention site for 1975.

Adjournment

The House of Delegates adjourned, *sine die*, at 6:55 p.m., Thursday, October 15, 1970.

THE WINNERS—121st Annual Convention South Bend Oct. 13-15, 1970

MEN'S ART AND HOBBY SHOW

Class I

1. Dr. Glen Hawkins, South Bend
2. Dr. T. T. Suzuki, Covington
3. Dr. Lester Borough, South Bend

Honorable Mention:

Dr. R. Hanneman, Lafayette

Class II

Dr. Glen Hawkins, South Bend

Color Photography

Dr. Robert Hanneman, Lafayette
Dr. D. Logan Dunlap, South Bend
Dr. Truman Caylor, Bluffton
Dr. William D. Ritchie, Evansville

Sculpture

Dr. Bernard Levatin, South Bend

Hobby

Dr. William D. Ritchie, Evansville

Special Exhibit

Dr. Delano Arvin, Lafayette
Dr. Burton Kintner, Elkhart
Dr. R. J. Morrical, Logansport

WOMAN'S AUXILIARY ART AND HOBBY SHOW

Class I

1. Mrs. Louis F. Sandock, South Bend
2. Mrs. Eldred MacDonell, South Bend
3. Mrs. William E. Wolf, LaPorte

Special Exhibit

Mrs. D. D. Stiver, South Bend

SCIENTIFIC EXHIBIT AWARD WINNERS

Award No. 1—Hudson Medical Group, Inc. (Edward P. Mininger, M.D., George Thompson, M.D., Henry Wishinsky, Ph.D., co-exhibitors), Elkhart—THE CLINICAL LABORATORY IN THE IDENTIFICATION AND MANAGEMENT OF THE HIGH RISK PREGNANCY PATIENT.

Award No. 2—Wilma F. Bergfeld, M.D., Cleveland, Ohio (James G. Ryan, M.D., F.R.C.P. (C), Henry H. Roenigk, Jr., M.D., S. Nakamoto, M.D., S. D. Deodhar, Ph.D., M.D. and R. R. Evans, M.D., co-exhibitors)—CUTANEOUS COMPLICATIONS OF IMMUNOSUPPRESSIVE THERAPY.

Award No. 3—Barry A. Goldsmith, M.D., Chicago (Milton W. Eisenstein, M.D., Chicago, co-exhibitor)—CHEMOSURGERY FOR RECURRENT AND INVASIVE CANCER OF THE SKIN.

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GRADUATE PHYSICIAN ASSISTANT wishes employment after December with a general practitioner who is overworked in his practice. Salary is negotiable. All inquiries should be sent to Danny P. Fox, Clinical Corpsman, Cleveland Clinic Hospital, Cleveland, Ohio 44130.

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RESIDENT PHYSICIAN

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The JOURNAL

of the

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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